

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 . 1 6 3 3 1 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
FIRST MIDDLE LAST MILLARD Jefferson ALMONY.				2a. DATE OF DEATH MONTH DAY YEAR 6 / 20 / 1983			
3. SEX MALE				2b. HOUR 10.05 AM			
4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pleasant Almony				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Almony			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-32-0120		17. INFORMANT ADDRESS Mary A. Almony same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 CORONARY ARTERY DISEASE. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, CONGESTIVE HEART FAILURE							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2) N/A.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A.			
22a. I certify that (I) (this hospital) attended the deceased from 6:20, 19 83, to 6:20, 19 83, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. S. PRABHU ASST. MEDICAL EXAM.		DEGREE MD FRCSENG. ATTENDING MEDICAL STAFF HARFORD COUNTY DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-20-1983.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. S. PRABHU		22e. ADDRESS FALLSTON GENERAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/22/1983		23c. NAME OF CEMETERY OR CREMATORY Ayres Chaple Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE White Hall, Harford, Md.	
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz				24b. ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR JUN 22 1983	
				25b. REGISTRAR'S SIGNATURE John J. Conner			

BP

3

Johnston

Feb. 17, 1955

Harry

William

Johnston

William

Robert

Robert

No

Johnston

CHIEF

6/22/1955 New Orleans La. to New York, N.Y.

Johnston, William

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 3 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DAVID CLEMENT AYRES			2a. DATE OF DEATH MONTH DAY YEAR 6-9-83			2b. HOUR 9:40 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DEC, 29, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH (21078) HAYRE de grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE LABORT		12b. KIND OF BUSINESS OR INDUSTRY Rail Road	
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2412 Main Street 21041	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Franklin AYRES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Anna Lutz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-10-8785		17. INFORMANT (Brother) 838-5146 ADDRESS Mr. U. Grant Ayres 8 North Atwood Road Bel Air, Maryland 21014			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) A.S. C.V.D.

DUE TO, OR AS A CONSEQUENCE OF

(c) Senility

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3-4 days

3-4 years

?

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

C.O.P.D., B.P.H.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/31, 19 83, to 6/9, 19 83, that (I) (we) last saw the deceased alive on 6/9, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.				DEGREE M.D.		22c. DATE SIGNED 6/9/83.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.				22e. ADDRESS Hayre de Grace, Md. 21078.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 13, 1983	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co, Maryland 21014
24. FUNERAL DIRECTOR Joseph William Foster Josephine Foster		25a. DATE REC'D. BY REGISTRAR JUN 13 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Section	Range	County	Acres	Owner
36	10	Wichita	160	Wichita Falls
35	10	Wichita	160	Wichita Falls
34	10	Wichita	160	Wichita Falls
33	10	Wichita	160	Wichita Falls
32	10	Wichita	160	Wichita Falls
31	10	Wichita	160	Wichita Falls
30	10	Wichita	160	Wichita Falls
29	10	Wichita	160	Wichita Falls
28	10	Wichita	160	Wichita Falls
27	10	Wichita	160	Wichita Falls
26	10	Wichita	160	Wichita Falls
25	10	Wichita	160	Wichita Falls
24	10	Wichita	160	Wichita Falls
23	10	Wichita	160	Wichita Falls
22	10	Wichita	160	Wichita Falls
21	10	Wichita	160	Wichita Falls
20	10	Wichita	160	Wichita Falls
19	10	Wichita	160	Wichita Falls
18	10	Wichita	160	Wichita Falls
17	10	Wichita	160	Wichita Falls
16	10	Wichita	160	Wichita Falls
15	10	Wichita	160	Wichita Falls
14	10	Wichita	160	Wichita Falls
13	10	Wichita	160	Wichita Falls
12	10	Wichita	160	Wichita Falls
11	10	Wichita	160	Wichita Falls
10	10	Wichita	160	Wichita Falls
9	10	Wichita	160	Wichita Falls
8	10	Wichita	160	Wichita Falls
7	10	Wichita	160	Wichita Falls
6	10	Wichita	160	Wichita Falls
5	10	Wichita	160	Wichita Falls
4	10	Wichita	160	Wichita Falls
3	10	Wichita	160	Wichita Falls
2	10	Wichita	160	Wichita Falls
1	10	Wichita	160	Wichita Falls

Wichita Falls, Texas, this 1st day of January, 1900.

Attest my hand and the seal of the Commission of the Land Office, this 1st day of January, 1900.

Wichita Falls, Texas, this 1st day of January, 1900.

Attest my hand and the seal of the Commission of the Land Office, this 1st day of January, 1900.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sally Bett Barker			2a. DATE OF DEATH MONTH DAY YEAR June 1 1983		2b. HOUR 4:20 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Hartford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --
13a. STATE Maryland			13b. COUNTY Hartford	13c. CITY OR TOWN Abingdon	
14. FATHER'S NAME FIRST MIDDLE LAST Bethuel -- Massie			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma -- (unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-01-7451-A		17. INFORMANT ADDRESS Carol Lynn Barker, Abingdon, Md. 21009 3506 Philadelphia Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 4292 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.U.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) C.O.P.D. with respiratory insufficiency, Pneumonitis					
19a. DATE OF OPERATION 5-18-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 6-1-83		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DATE OF OPERATION 5-18-83		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED 6-1-83		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-18-83 to 6-1-83 , that (I) (we) lost saw the deceased alive on 6-1-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE M.D.		22c. DATE SIGNED 6/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, M.D.		22e. ADDRESS Hartford, Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 4, 1983		23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Cemetery, Joppa	
24. FUNERAL DIRECTOR NAME Howard K. McComas III		ADDRESS Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JUN 3 1983	
				25b. REGISTRAR'S SIGNATURE John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 6 3 3 4	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST LILLIAN CONNER BARRETT				2a. DATE OF DEATH MONTH DAY YEAR 6-5-83		2b. HOUR 12:34A			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6-14-15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF KNOWN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15 West Darnestville Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST KYLE K. CONNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA BEBLE SARTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown				16b. SOCIAL SECURITY NO. 216-48-3554		17. INFORMANT ADDRESS Harold Barnett 15 W. Darnestville Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Herniation 4310 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive Intracranial Hemorrhage. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Wandering Atrial Pacemaker & AV dissociation.											
19a. DATE OF OPERATION _____				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 6-2 , 19 83 , to 6-5 , 19 83 , that (we) last saw the deceased alive on 6-5 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George H. Ordonez Smith				22e. ADDRESS Fallston, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 7, 1983		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Colora Cecil MD			
24. FUNERAL DIRECTOR NAME ADDRESS John H. Harkins, 600 Main St., Delta, PA						25a. DATE REC'D. BY REGISTRAR JUN 8 1983		25b. REGISTRAR'S SIGNATURE [Signature]			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 16335

1- FOR
STATE
REGISTRAR

REG. NO.

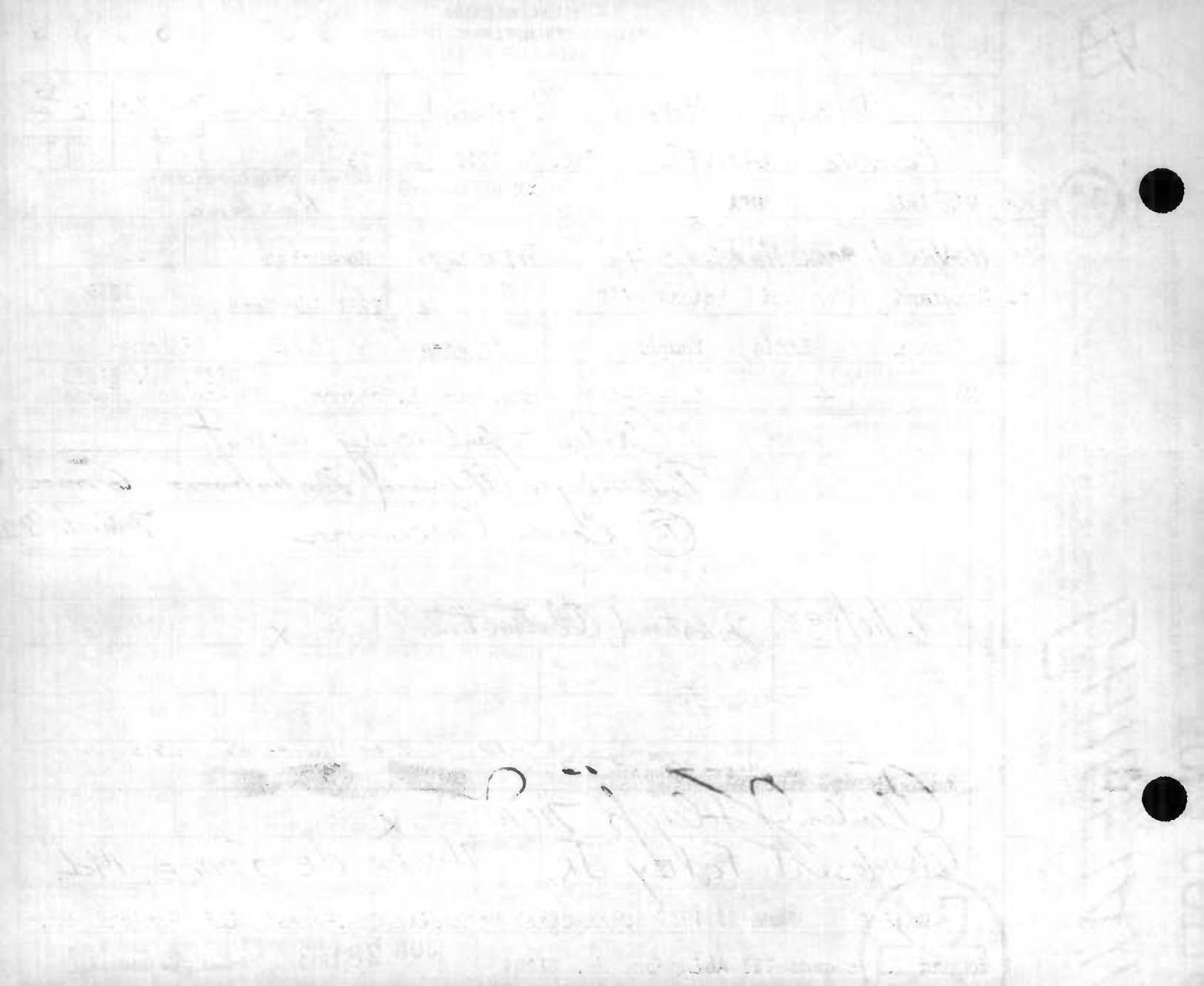
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DIXIE Hazel BARROW			2a. DATE OF DEATH MONTH DAY YEAR June 25 83		2b. HOUR 10:35 AM
3. SEX Female	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY --
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Forest Hill 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 2231 Ady Road 13f. ZIP CODE 21050					
14. FATHER'S NAME FIRST MIDDLE LAST George Ellis Vaughan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genetta Ellen Gilham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-09-0603		17. INFORMANT ADDRESS Mrs. Janet L. Wagoner, 2233 Ady Road, Forest Hill, Md. 21050	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 1536 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary & Abdominal Metastases (c) Colon Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. March '82					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION 6/10/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March , 19 82 , to June 25 , 19 83 , that (I) (we) last saw the deceased alive on June 25 , 19 83 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE OF PHYSICIAN Charles J. Foley Jr. M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. FOLEY JR.			22e. ADDRESS HARFORD DE GRACE, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 28, 1983	23c. NAME OF CEMETERY OR CREMATORY Deer Creek Methodist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill Harford Md.
24. FUNERAL DIRECTOR NAME Howard K. McComas III			24b. ADDRESS Abingdon, Md. 21009		
25. DATE REC'D. BY REGISTRAR JUN 28 1983			25b. REGISTRAR'S SIGNATURE John J. Conner		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

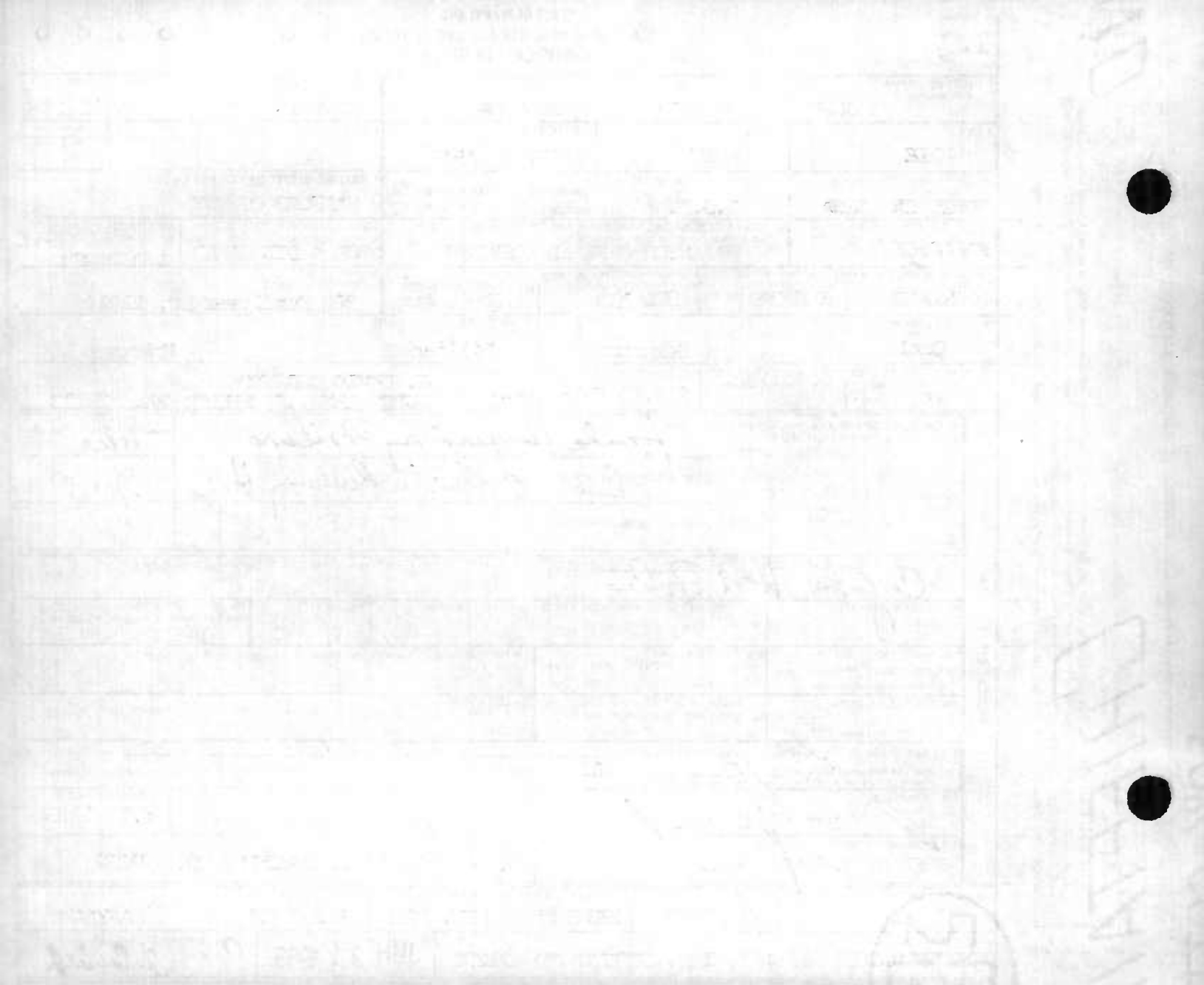
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 6 3 3 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN RIDDICK BERGERON				2a. DATE OF DEATH MONTH DAY YEAR JUNE 15, 1983				2b. HOUR 12:25 P M			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 3, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOL & DIE MAKER		12b. KIND OF BUSINESS OR INDUSTRY AEROSPACE & DEFENSE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY HARFORD		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 300 Sunflower Dr. 21014	
14. FATHER'S NAME FIRST MIDDLE LAST Carl Bergeron				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216.03.5818		17. INFORMANT ADDRESS J. DAVID BERGERON 2701 SANDHURST LANE, RICHMOND, VA. 23113							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Respiratory Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c): Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE HRs Yours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Congenital Heart Failure											
19a. DATE OF OPERATION 6/7				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Congestive Heart Failure				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 59 DUNDALK AVE., DUNDALK, MD. 21222							
22a. I certify that (I) (this hospital) attended the deceased from 19 74 , to 6/7/83 , that (I) (we) last saw the deceased alive on 6/7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jose M. Yosunico				DEGREE MD.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/17/1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. YOSUNICO, M.D.				22e. ADDRESS 59 DUNDALK AVE., DUNDALK, MD. 21222							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/18/1983		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK				23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE MARYLAND			
24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY, INC. DUNDALK MD 21222				25a. DATE REC'D. BY REGISTRAR JUN 21 1983		25b. REGISTRAR'S SIGNATURE J. C. Conner					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 6 3 3 7			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Faith		MIDDLE Viola		LAST Bishop		2a. DATE OF DEATH		MONTH 6	DAY 26	YEAR 83	2b. HOUR 11:10 A M
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 1 DAY 22 YEAR 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford county MD.							
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Beauty					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 412 Meadowood Drive 21040					
14. FATHER'S NAME FIRST William		MIDDLE --		LAST Bishop		15. MOTHER'S MAIDEN NAME FIRST Octavia		MIDDLE --		LAST Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS Forest Hill, Md. 21050		Mrs. Nellie Downing, 2220 Johnson Mill Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac, Renal & Resp. Failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) D.M. Lupus Erythematosus, GI bleeding 1 week. DUE TO, OR AS A CONSEQUENCE OF "Vasculitis". (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6-18, 1983, to 6-26, 1983, that (I) (we) last saw the deceased alive on 6/28, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE B. Parekh		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-26-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD		1908 Harford Rd. Fall		22e. ADDRESS 1908, Harford Rd. Fallston MD 21047									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 29, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN Tappa		COUNTY Harford		STATE Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 28 1983		25b. REGISTRAR'S SIGNATURE John J. Connel							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 1 6 3 3 8
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minerva Moore Bishop			June 27 1983			10 p.m.				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 9-12-1895		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wilmington, Del.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
10 CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Balto		13c CITY OR TOWN Baldwin		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph A Moore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Morrisson			13e STREET ADDRESS 3009 Moores Road			21013	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 222-20-0081		17 INFORMANT Carolyn A. Hise			ADDRESS 3009 Moore Rd. Baldwin		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2639 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Suspected Septic DUE TO, OR AS A CONSEQUENCE OF (c) Melanoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Myocardial Heart Disease, Recent Hx of Pneumonia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR not applicable			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (STREET, CITY OR TOWN, COUNTY, STATE)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Sept 28 19 81 to June 27 19 83 , that (I) (we) last saw the deceased alive on 4-27 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE MIS			DEGREE MD			22c. DATE SIGNED 6/27/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZAR, MANUEL			22e. ADDRESS 1131 Bel Air Rd, Bel Air, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE June 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Spicer-Mulligan F.H.		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington-New Castle Del.			
24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR JUL 1 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		8 3 1 6 3 3 9	
1. DECEASED NAME (TYPE OR PRINT) Rosa Helen Blake			
2a. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR 19	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH 7 DAY 5 YEAR 21	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION FALLSTON GEN. Hosp.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY HARFORD	
13c. CITY OR TOWN Whiteford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2412 Whiteford Road		13f. CITY OR TOWN 21160	
14. FATHER'S NAME FIRST John MIDDLE Workman LAST Priscilla		15. MOTHER'S MAIDEN NAME FIRST Priscilla MIDDLE Gross LAST Gross	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 183-18-7336	
17. INFORMANT Dudley E. Blake, Whiteford, Maryland		17c. DATE 2412 Whiteford Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE. 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ATHEROSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) NONE			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). NONE			
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR N/A CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N/A	
21f. LOCATION STREET N/A CITY OR TOWN N/A COUNTY N/A STATE N/A		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE Ganesha Prashu		TITLE (SPECIFY) M.D.	
EXAMINER'S NAME (TYPE OR PRINT) GANESETH PRASHU		ADDRESS DATE SIGNED JUNE 30 83.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 4, 1983	
23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery		23d. LOCATION CITY OR TOWN Delta COUNTY York STATE Penna.	
24. FUNERAL DIRECTOR NAME John H. Harkins ADDRESS 600 Main St., Delta, PA. 17314		25a. DATE REC'D. BY REGISTRAR JUL 11 1983 REGISTRAR'S SIGNATURE John J. Gansh	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-335-1200.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8316340			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Richard OWEN Blocher, Jr.</u>				2b. HOUR <u>9:02 A.M.</u>			
3. SEX <u>MALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>April 23, 1918</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>65</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford Co.</u> MD.	
10. CITY OR TOWN OF DEATH <u>Belt Air</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>917 Wheel Road</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Equipment Manager</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Harford Co.</u>		13c. CITY OR TOWN <u>Belt Air (21014)</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Richard OWEN Blocher, Sr.</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MADEL CATHERINE ZUMSTEIN</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>220-05-3192</u>	
17. INFORMANT (NAME) <u>Mrs. Susan Virginia Blocher</u>		17. ADDRESS <u>917 Wheel Road, Belt Air, Maryland 21014</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u>		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/3/1983</u> to <u>5/6/1983</u> , that (I) (we) lost the deceased alive on <u>5/6/1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Myo Than</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>JUNE 23, 1983</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MYO THAN, M.D.</u>		22e. ADDRESS <u>9101 FRANKLIN SO. DR. BALTO, MD 21237</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>JUNE 25, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Meth. Ch. Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Belt Air, Harford Co., Maryland 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		ADDRESS <u>W. Broadway & Williams St., Belt Air, Maryland 21014</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 28 1983</u> 25b. REGISTRAR'S SIGNATURE <u>John J. Gough</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 4 1

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Albert Bond			2a. DATE OF DEATH MONTH 6 DAY 15 YEAR '83			2b. HOUR 8 P. M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH 1 DAY 29 YEAR 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harvre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Taxi Driver	
12b. KIND OF BUSINESS OR INDUSTRY Retired		13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Harvre de Grace	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4132 Gravel Hill Rd.		13f. STREET ADDRESS 21078			
14. FATHER'S NAME FIRST William MIDDLE Bond LAST Bond		15. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE Pugh LAST Pugh		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-09-1543	
17. INFORMANT James W. Bond		ADDRESS 3187 Georgian Woods Circle		CITY Decatur, Georgia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hypertension, Arthritis, Gastritis, COPD, Anemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-2-83 , 19 83 , to 6-15 , 19 83 , that (I) (we) last saw the deceased alive on 6-15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howlett Jackson				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6.15.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howlett Jackson				22e. ADDRESS 1315 Union Ave Harvre De Grace Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/18/83		23c. NAME OF CEMETERY OR CREMATORY St. James AME Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harvre De Grace Harford Md.	
24. FUNERAL DIRECTOR NAME Arnold Beard ADDRESS 353 Fountain St. Harvre De Grace, Md.				25a. DATE REC'D. BY REGISTRAR JUN 17 1983 REGISTRAR'S SIGNATURE John J. Canine			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

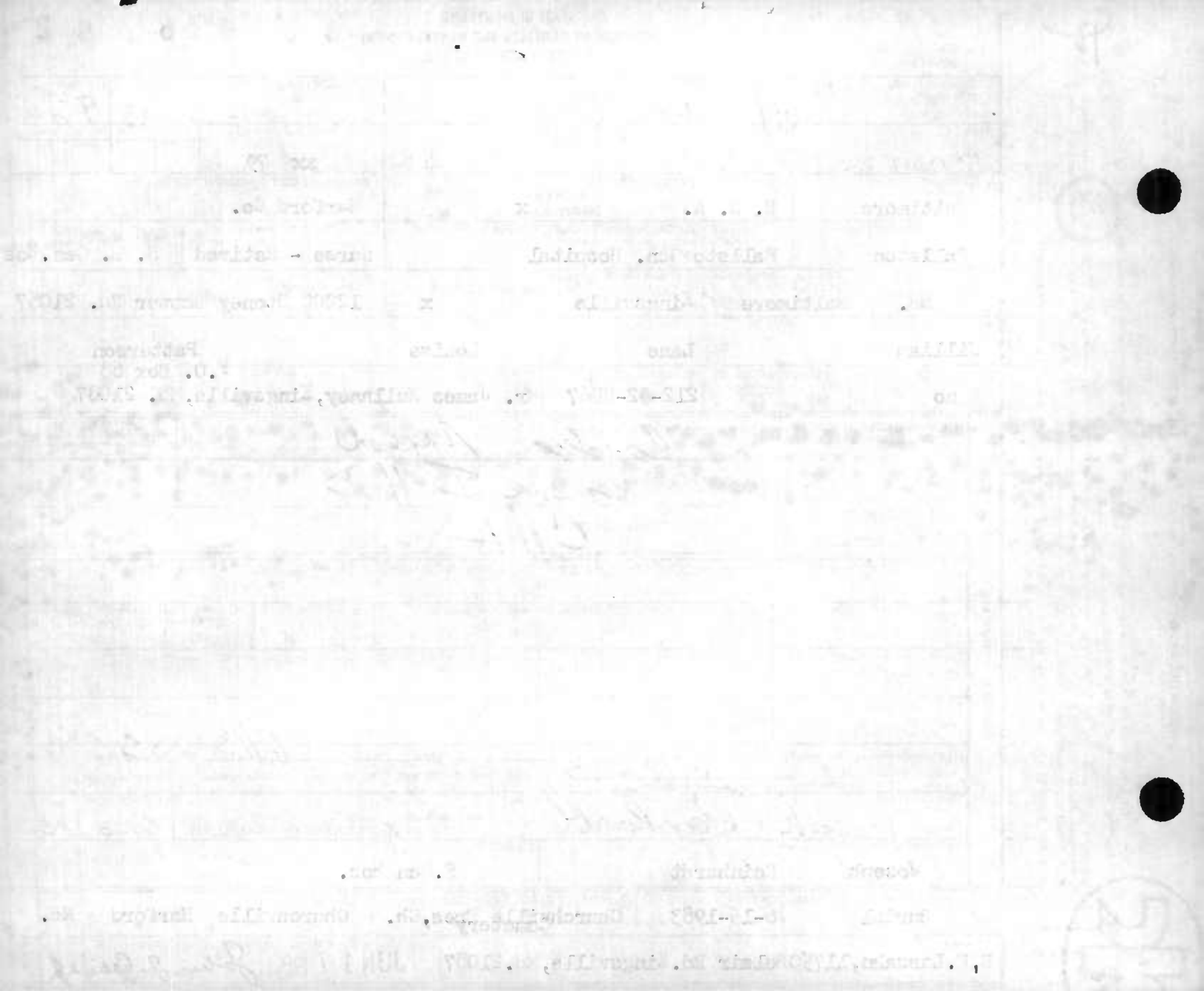
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 6 3 4 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>EDYTH P. BOWERS</u>				2a. DATE OF DEATH MONTH <u>6</u> DAY <u>13</u> YEAR <u>83</u>		2b. HOUR <u>9:45</u> AM	
3. SEX <u>FEMALE</u>		4. RACE <u>CAUCASION</u>		5. DATE OF BIRTH MONTH <u>4</u> DAY <u>9</u> YEAR <u>04</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford Co.</u> MD.	
10. CITY OR TOWN OF DEATH <u>Fallston</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fallston Gen. Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Nurse - Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>S. B. Gen. Hos.</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Kingsville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>Lane</u> LAST <u>Lane</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Louise</u> MIDDLE <u>Patterson</u> LAST <u>Patterson</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> (IF YES, GIVE WAR OR DATES)			
16a. SOCIAL SECURITY NO. <u>212-32-8867</u>		17. INFORMANT ADDRESS <u>P.O. Box 68</u> <u>Mr. James Mullaney, Kingsville, Md. 21087</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4149</u> IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Severe I. H. D.</u> IS. HEART DIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF <u>CHF</u> (c) <u>CHF</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/12/83</u> , 19 <u>83</u> , to <u>6/13/83</u> , 19 <u>83</u> , that (I) (we) lost <u>above</u> , (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joseph Reinhardt</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/13/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph Reinhardt</u>				22e. ADDRESS <u>F. Gen. Hos.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6-15-1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Churchville Pres. Ch. Cemetery</u>		23d. LOCATION <u>Churchville Harford Md.</u>	
24. FUNERAL DIRECTOR <u>E. F. Lassah, 11750 Belair Rd. Kingsville, Md. 21087</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 17 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

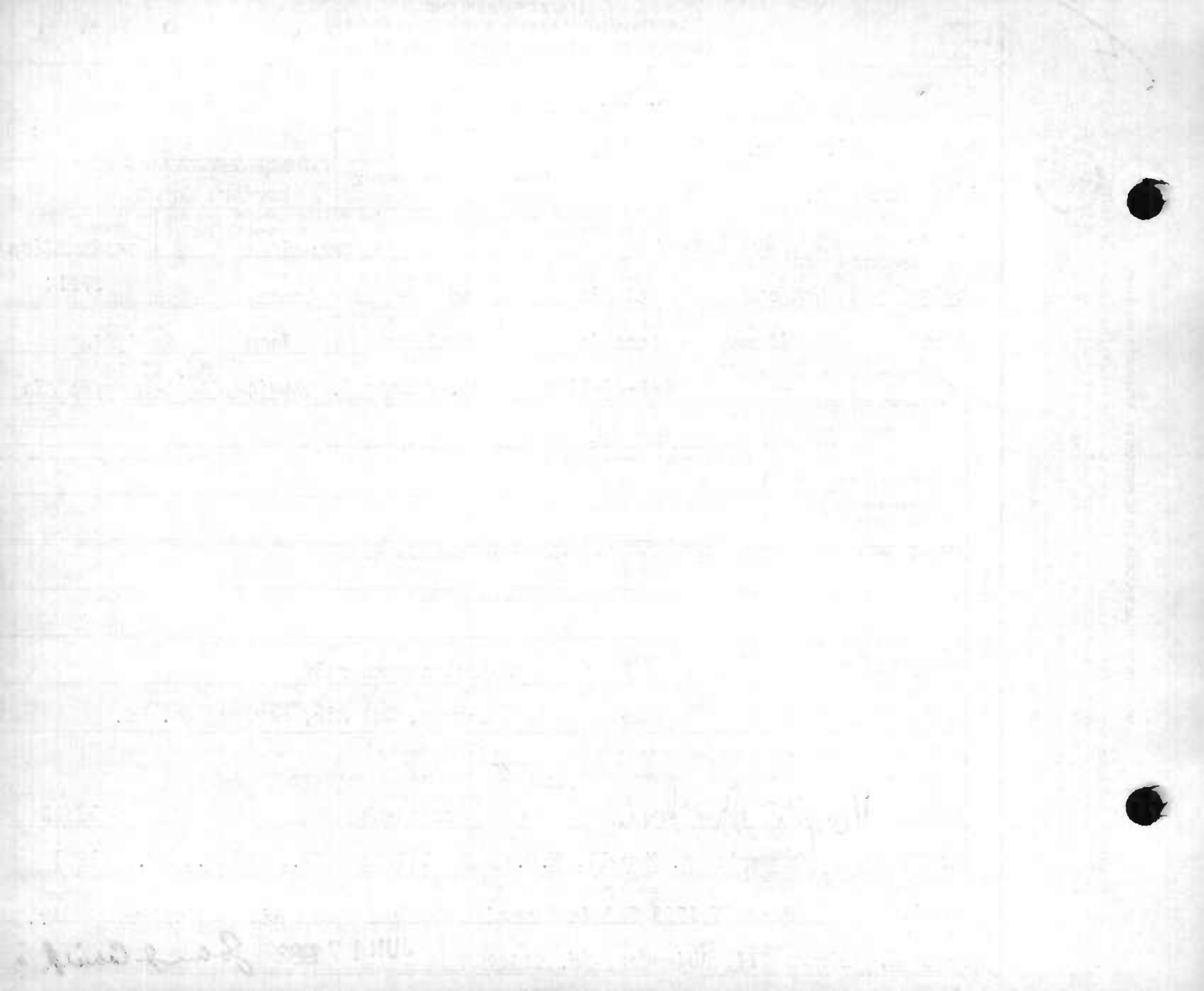
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 6 3 4 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>SAMUEL</u> MIDDLE <u>CHRISTIAN</u> LAST <u>BRANHAM</u> <i>SAMUEL CHRISTIAN BRANHAM</i>				2a. DATE OF DEATH MONTH DAY YEAR <u>6</u> <u>11</u> <u>83</u>		2b. HOUR <u>11:05 PM</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>May 28, 1911</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD</u> MD.	
10. CITY OR TOWN OF DEATH <u>Fallston</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FALLSTON GEN HOSP</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Agent</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Real estate</u>	
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Darlington</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Edmund -- Branham</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elena Nora Willis</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>224-03-0353</u>		17. INFORMANT ADDRESS <u>Mrs. Anna May Branham, Darlington, Md. 21034</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepato-renal failure</u> <u>1539</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Cancer of Colon</u> (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 1/2 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>6/11/83</u> to <u>6/12/83</u> , that (1) (we) lost <u>saw</u> the deceased alive on <u>6/11/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Willard P. Amoss</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/12/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Willard P. Amoss</u>		22e. ADDRESS <u>2303 Sp/air Rd Fallston Md 21047</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June 15, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Harford Md.</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Howard K. McComas III, Abingdon, Md. 21009</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 14 1983</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16344	
1. DECEASED NAME (TYPE OR PRINT) Robert Alfred Breswick										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 6/7/83	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 9, 1955		6. AGE (IN YEARS) 27 YRS		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 6/12/83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ridley Park, Pa.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
10. CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 604 Leeway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 604 Leeway 21014	
14. FATHER'S NAME Alfred Willner Breswick				15. MOTHER'S MAIDEN NAME Barbara Joan Schilling				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) --			
16a. SOCIAL SECURITY NO. 166-48-1108				17. INFORMANT Mrs. Barbara J. Breswick				ADDRESS Md. 21014 604 Leeway, Bel Air			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 6/7/83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TB PART 1 OR PART 2) subject hanged self			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION 604 Leeway, Bel Air, Harford Co. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 6/13/83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., Md., 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 17, 1983		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III				ADDRESS Abingdon, Md. 21009				25a. DATE REC'D BY REGISTRAR JUN 17 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

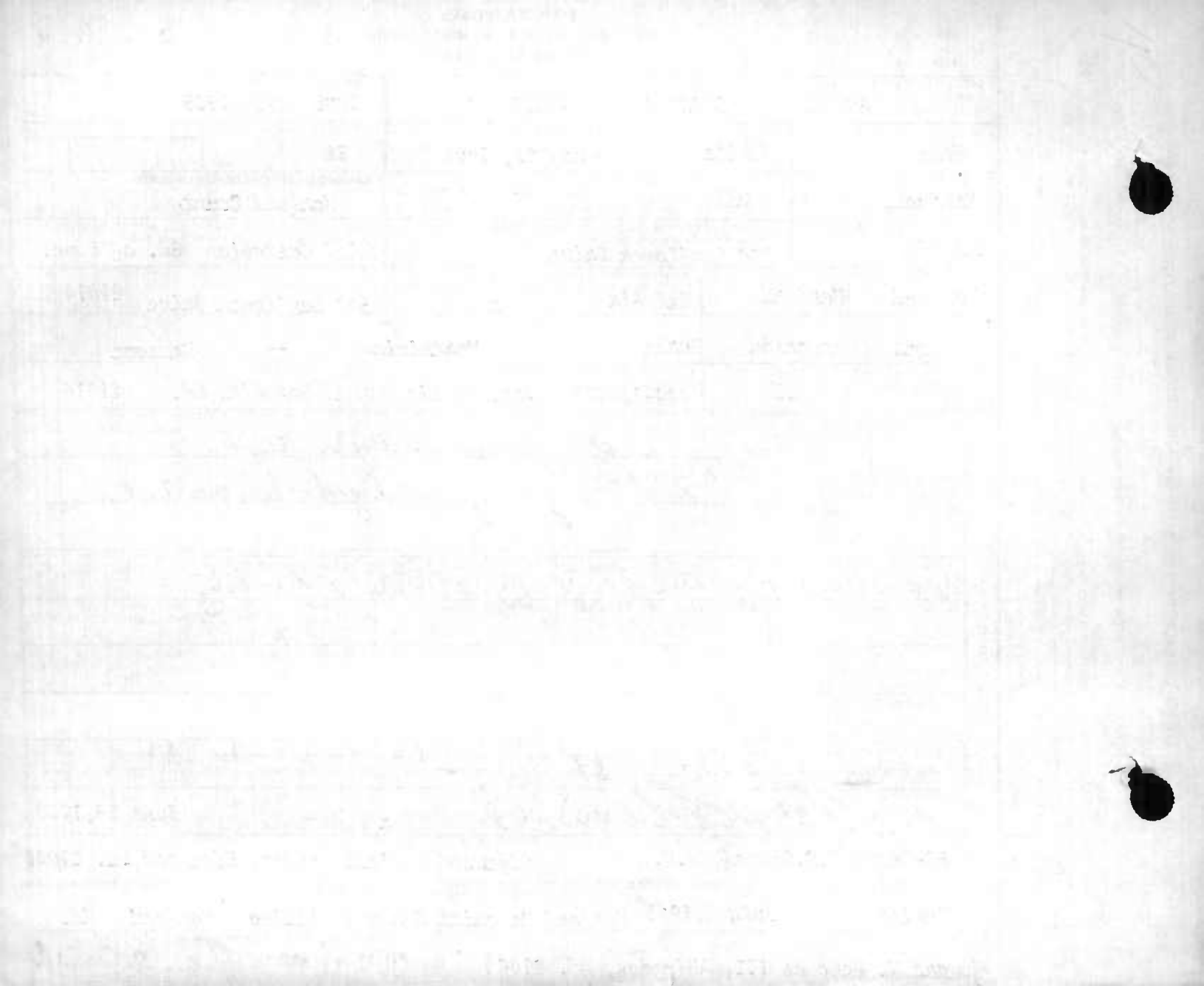
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR					8 3 1 6 3 4 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREW JACKSON BURKE					2a. DATE OF DEATH MONTH DAY YEAR JUNE 29, 1983			2b. HOUR M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 22, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 Sunflower Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Custodian		12b. KIND OF BUSINESS OR INDUSTRY Ed. of Educ.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Bel Air					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 300 Sunflower Drive 21014		
14. FATHER'S NAME FIRST MIDDLE LAST James Henderson Burke					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vertricia -- Newsome				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Mrs. Nellie Burke, Bel Air, Md.		ADDRESS 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>end stage generalized arteriosclerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>Stroke, prostate hypertrophy, arthritis, debility</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-11</u> , 19 <u>82</u> , to <u>6-29</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>6-16</u> , 19 <u>83</u> , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>M. Sharfdean</u> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED June 29, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) El-Deane M.S. Sharaf, M.D.					22e. ADDRESS Edgewood Medical Center, Edgewood, Md. 21040				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 2, 1983		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens, Aldino			23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009					25a. DATE REC'D. BY REGISTRAR JUN 30 1983		25b. REGISTRAR'S SIGNATURE <u>John A. Gair</u>		

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

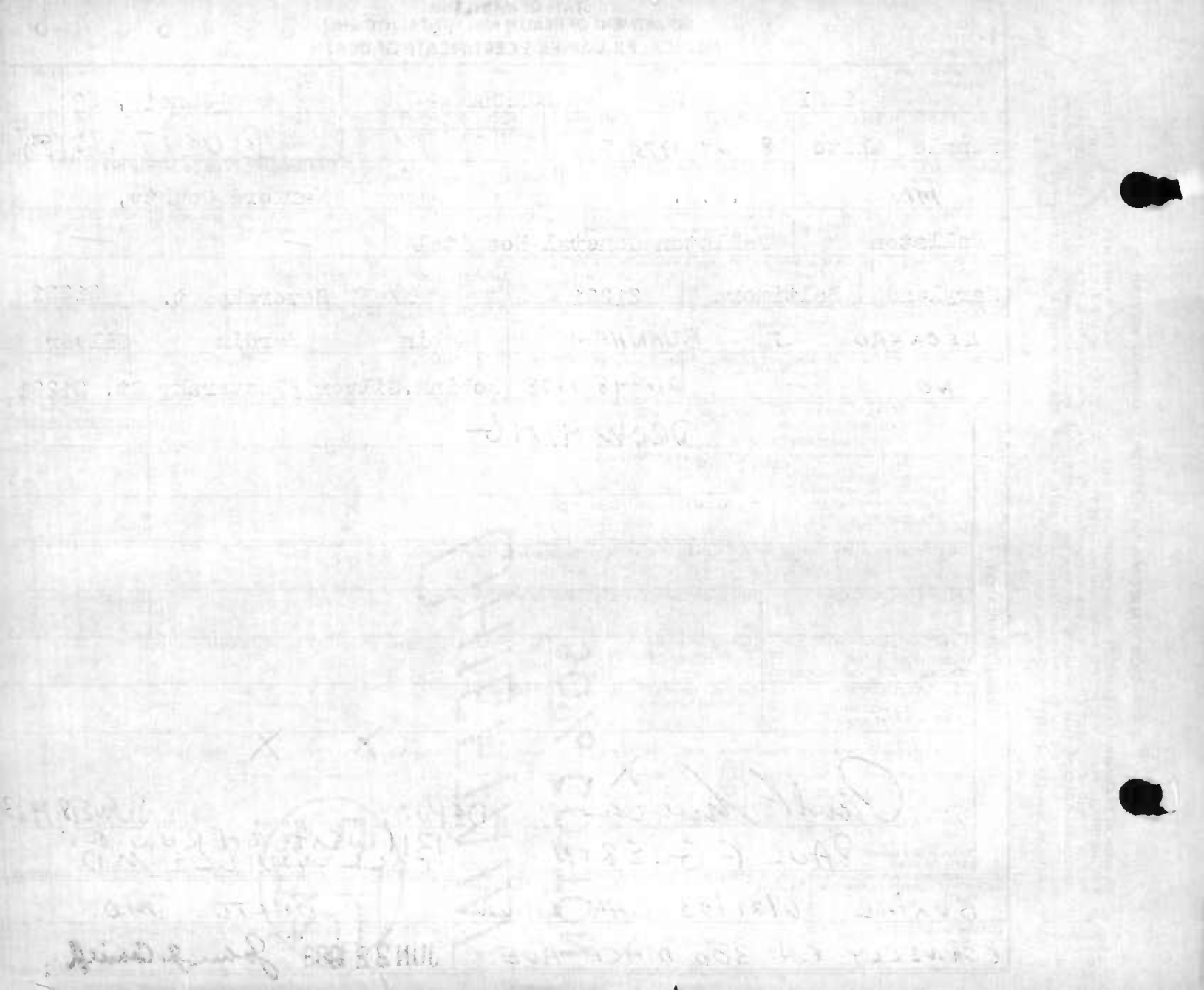
DHMH - 17
(VR A15 ME (5))
15M/7/77

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
TONY		JO		BURNHAM				June 17, 1983										PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	8 29 1973		7 YRS.						JUNE 17 1983								PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
MD.		U.S.A.		WIDOWED		DIVORCED		Harford County,										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Fallston		Fallston General Hospital																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Baltimore		21221		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		57 Seversky Ct.										21221	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
LEONARD		J.		BURNHAM		Robin		Hardin		Silver									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		216-98-1278		Robin H. Silver		57 Seversky Ct.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
9109		IMMEDIATE CAUSE (a)		DROWNING															
		DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion											
death resulted from:		Natural cause <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D.		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
PAUL K GUERIN				DEPUTY				JUNE 18, 1983											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
PAUL K GUERIN		1311 WESTERN ROW RD COCKEYSVILLE MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
BURIAL		6/21/83		OAK LAWN		BALTO		MD.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
CONNELLY F.H.		300 MACE AVE		JUN 22 1983		John J. Connelly													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Luther J. Bush</u>			2a. DATE OF DEATH MONTH <u>06</u> DAY <u>16</u> YEAR <u>83</u>		2b. HOUR <u>11:26</u> P.M.
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>Sept.</u> DAY <u>13</u> YEAR <u>1899</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Hartford</u> MD.		
10. CITY OR TOWN OF DEATH <u>Fallston</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fallston Gen Hosp</u>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Hartford</u>	13c. CITY OR TOWN <u>Pylesville</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>711 Old St. Mary's Rd.</u>
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Ellsworth</u> LAST <u>Bush</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Sarah</u> MIDDLE <u></u> LAST <u>Curry</u>		ADDRESS <u>2905 Ady Rd.</u> <u>Forest Hill, Md.</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>215-36-8250</u>		17. INFORMANT <u>Marjaret Hankins</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <u>4292</u> IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <u>6/9/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CHOLECYSTITIS</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>4/4</u> , 19 <u>83</u> , to <u>6/16</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>6/16</u> , 19 <u>83</u> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.					
22b. SIGNATURE <u>R. Phillips</u>		DEGREE		22c. DATE SIGNED <u>6/17/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. PHILLIPS</u>		22e. ADDRESS <u>1716 Hartford Rd</u>		<u>Fallston 21047</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6-20-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gdns</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hartford Co., Md.</u>		24. FUNERAL DIRECTOR NAME ADDRESS <u>John H. Harkins, 600 Main St. Delta, Pa.</u>			
25a. DATE REC'D. BY REGISTRAR <u>JUN 23 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Gurnea</u>			

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine J. Byer			2a. DATE OF DEATH MONTH DAY YEAR 6- 24-1983			2b. HOUR 11:30 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-- 20--1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Jarrettsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1626 N. Bend Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Home Making	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1626 N. Bend Rd. 21084	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Heisterhagen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Rott			16. ADDRESS 1626 N. Bend Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 218-03-7223		17. INFORMANT Mrs. Edna A. Guckert, Jarrettsville, Md. 21084					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> 5990 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary Tract Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 5-7 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Multiple Cerebral Vascular Accidents & Severe Dementia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 18</u> , 19 <u>83</u> , to <u>June 24</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>June 18</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Randall C. Cronin, Jr.</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/25/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Randall C. Cronin, Jr.				22e. ADDRESS 721 Wheeler School Rd. Whitehead, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-27-1983		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rosedale Baltimore Md.			
24. FUNERAL DIRECTOR E. F. Lassahn, 11750 Belair Rd. P. O. Box 11750, Baltimore, Md. 21287				25a. DATE REC'D. BY REGISTRAR JUN 30 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10-10-10

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10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 6 3 4 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John Alfred Campbell				2a. DATE OF DEATH MONTH DAY YEAR June 2, 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 21, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Ret.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. STREET ADDRESS 296 Post Rd. 21911	
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert Campbell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Holland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 218-18-2207		17. INFORMANT ADDRESS Mrs Dorothy Abrams- Sister- Same as above	
18. CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2377 IMMEDIATE CAUSE (a) Neurofibromatosis TCNS DUE TO, OR AS A CONSEQUENCE OF (b) Enlargement, Sarcoma of DUE TO, OR AS A CONSEQUENCE OF (c) Fibroma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/20, 1970, to 6/2, 1983, that (I) (we) last saw the deceased alive on 6/2, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dudley Phillips MD				DEGREE MD		22c. DATE SIGNED 6/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dudley Phillips MD				22e. ADDRESS DARLINGTON, Md 21034			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 4, 1983		23c. NAME OF CEMETERY OR CREMATORY Calvert Friens Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun Cecil Md.	
24. FUNERAL DIRECTOR NAME Richard L. Goodie				ADDRESS Rising Sun, Md.		25a. DATE REC'D. BY REGISTRAR JUN 6 1983	
				25b. REGISTRAR'S SIGNATURE John J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			8 3 1 6 3 5 0 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Thomas Julian Cassidy						June 5, 1983			M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
Male	White	July 16, 1916		66		YRS.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Harford MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Aberdeen		1425 Old Stepney Road 21002				Truck Driver		Transfer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			Harford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Abingdon, MD 21009		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS				
George Cassidy			Agnes M. Bowling		215 Lou-Mar Estates				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO			219-03-3082		Irene M. Cassidy 215 Lou-Mar Estates				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4370 Chronic Congestive HF failure (b) 49ns Due to, OR AS A CONSEQUENCE OF Syst & Cerebral Arteriosclerosis (c) 49ns Due to, OR AS A CONSEQUENCE OF Cardiac Resuscitant TIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/18/78, 19____, to 6/5/83, 19____, that (I) (we) last saw the deceased alive on 5/17, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Dudley Phillips			DEGREE MD		22c. DATE SIGNED 4/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Dudley Phillips, MD			Masonic Building, Darlington, MD 21034						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			June 8, 1983		St. Pauls Lutheran Cem.		Aberdeen Harford MD		
24. FUNERAL DIRECTOR (NAME ADDRESS)			25a. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE			
Tarring Funeral Home, P.A. Aberdeen, MD 21001-3399			JUN 9 1983			John J. Carver			

CONCLUSION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 5 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence Viola Clapper</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 2, 1983</i>		2b. HOUR <i>12:30 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 20, 1883</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>99</i>		
10. CITY OR TOWN OF DEATH <i>Bel Air</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bel Air Convalescent Center</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford County</i> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>--</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Joppa</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel L. Price</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary -- Davies</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>213-36-0137</i>		17. INFORMANT ADDRESS <i>Mrs. Myra E. Reeves, 1607 Philadelphia Road Joppa, Md. 21085</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4149 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ischemic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5/9 1983</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>6/2 1983</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I, this hospital) attended the deceased from <i>October 5/9 1983</i> to <i>6/2 1983</i> , that (I, we) lost saw the deceased alive on <i>5/9 1983</i> , and that in (my, our) opinion death occurred on the date and hour and from the causes stated above, (I, we) (did not) view the body after death.						
22b. SIGNATURE <i>Andrew Nowakowski MD.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/2/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>June 4, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mountain Christian Cemetery, Joppa Harford Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md. 21009</i>		25. DATE REC'D. BY REGISTRAR <i>JUN 6 1983</i>				

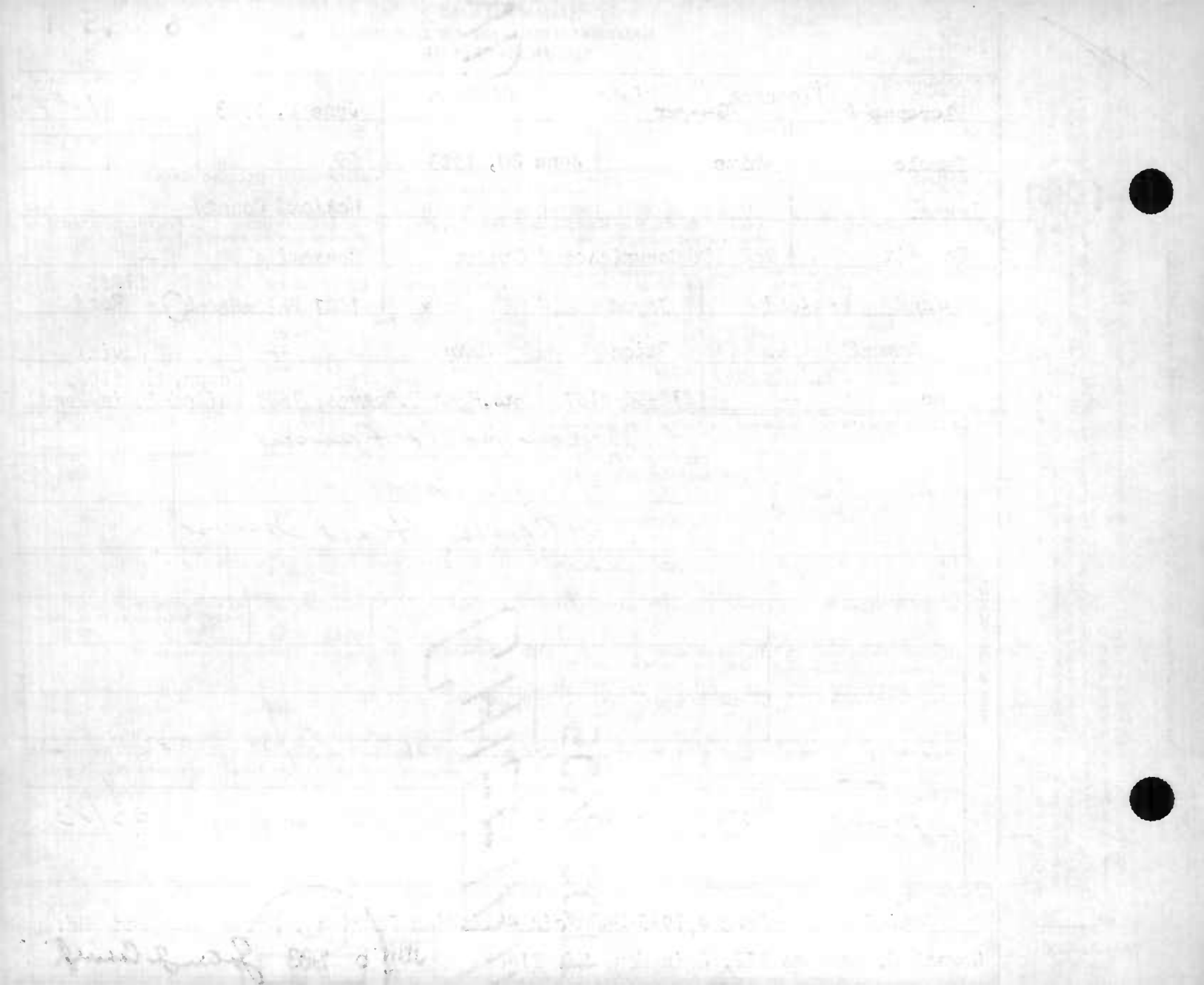
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

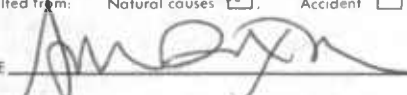

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
20M 4/82

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) GEORGE E. CLAVELL, JR.						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 14 19 83		2b. HOUR M 12:05			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 29	6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 23 19 83		2d. HOUR P M D M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) field - 1007 Stepney Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attendent at Gas		12b. KIND OF BUSINESS OR INDUSTRY Station			
13a. STATE Md.		13b. COUNTY Harford Co.		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1007 Stepney Rd. 21001			
14. FATHER'S NAME FIRST MIDDLE LAST George E. Clavell Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Hare					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Melvin W. Clavell Owings Mills, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 6-23-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/25/83		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md.						25a. DATE REC'D. BY REGISTRAR JUL 6 1983		25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 6 3 5 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST AGNES MIDDLE MARIE LAST COLLINS AGNES MARIE COLLINS				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR (JUNE 8, 1983) 6 8 83 5 4 A.M.			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 4, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON (21047)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah McVicker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 012-05-1401-A	
17. INFORMANT (Relationship) 838-9879 ADDRESS Mr. George L. Collins, Sr. Bel Air, Maryland 21014				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4310 Cardiorespiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhagic stroke Brain stem. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 to 6/8/83 5 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 7, 1983 to June 8, 1983, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Albert S. C. Sun, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. Sun, M.D.				22e. ADDRESS 1800 Harford Rd. Fallston, 21047			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE JUNE 10, 1983		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral				W. Broadway & Williams St. BEL AIR, Maryland 21014		25a. DATE REC'D. BY REGISTRAR JUN 10 1983	
				25b. REGISTRAR'S SIGNATURE Joan J. Conner			

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 1 6 3 5 4
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LAURA J. Creswell			2a. DATE OF DEATH MONTH DAY YEAR JUNE 10th 1983		2b. HOUR 1:56 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR JUNE 18 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Weaver	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 244 Old Farmington Road 21901	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Craig		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-09-8892		17. INFORMANT Thomas E. Creswell ADDRESS 244 Old Farmington Road North East Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4310 Respiratory arrest**

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

(b) **Pressure cerebral hemorrhage**

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **1 day**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-5-83 to 6-10-83 , that (I) (we) last saw the deceased alive on 6-10-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE John H. McGraw DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 15, 1983	23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Maryland
24. FUNERAL DIRECTOR NAME Geoffrey Funeral Home ADDRESS 259 East Main St. Elkton Md.		25. DATE REC'D. BY REGISTRAR JUN 16 1983 REGISTRAR'S SIGNATURE John J. Canfield	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

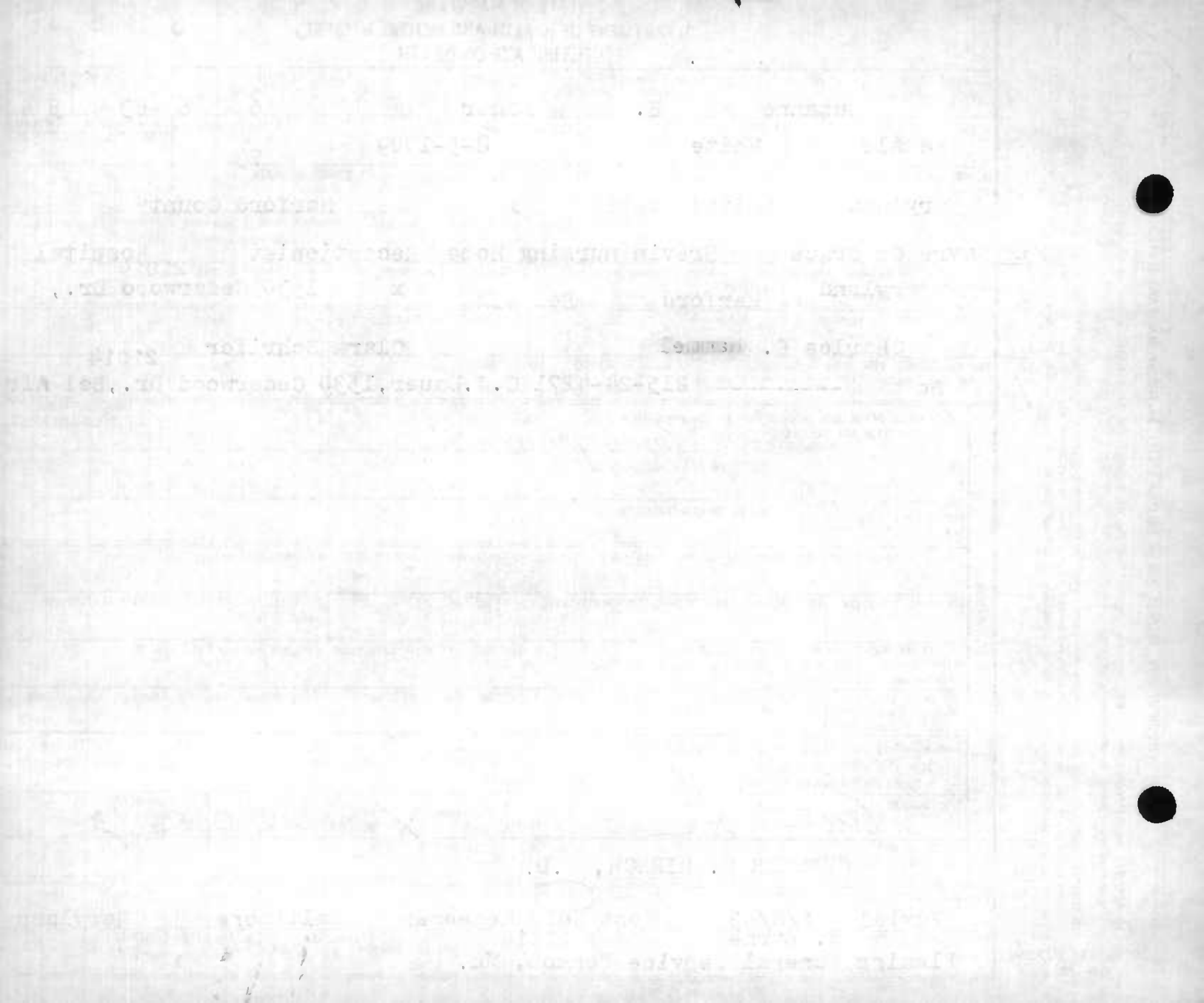
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Suzanne B. Dauer			2a. DATE OF DEATH Month 6 Day 6 Year -83			2b. HOUR 5 A M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-5-1909		6. AGE (In years lost birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford County Md.				
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brevin nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Receptionist			12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 21014 1530 Cedarwood Dr.,	
14. FATHER'S NAME First Charles E. Middle Hammel Last			15. MOTHER'S MAIDEN NAME First Clara Middle Schrifer Last			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)				
16a. SOCIAL SECURITY NO. 215-24-4271			17. INFORMANT Address 21014 C.J. Dauer, 1530 Cedarwood Dr., Bel Air							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natily medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Gunther D. Hirsch						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/6/83		
22d. PHYSICIAN'S NAME (Type) GUNTHER D. HIRSCH, M.D.			22e. ADDRESS							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/8/83		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR E. Barnes			ADDRESS 21018			25a. REC'D. BY REGISTRAR DATE JUN 8 1983		25b. REGISTRAR'S SIGNATURE John L. Connel		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

16356

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marsha Kitoya Foster			2a. DATE OF DEATH MONTH DAY YEAR June 28 83		2b. HOUR 10 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 28 83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 57	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH HAVER, de GRACE Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md		13c. CITY OR TOWN Harford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rural Route 2904	
14. FATHER'S NAME FIRST MIDDLE LAST Marshall Lundy Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Andrea Kitoya Foster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Andrea Foster 4019 Alameda Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7650 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE PREMATUREITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-28, 19 83, to 6-28, 19 83, that (I) (we) last saw the deceased alive on 6-28, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE J. RASTOGLI		DEGREE		27c. DATE SIGNED 6/28/83	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) J. RASTOGLI		27e. ADDRESS HARFORD MEM. HOSP. Hdq.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/9/83		23c. NAME OF CEMETERY OR CREMATORY St. James ANE Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.	
24. FUNERAL DIRECTOR NAME Arnold Beard 353 Fountain St. Harford Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 11 1983	
				REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is to determine the effect of temperature on the rate of reaction of hydrogen peroxide with potassium iodate in the presence of a catalyst. The organization of the project is as follows: a general description of the project, a description of the experimental procedure, a description of the results, and a conclusion.

2. The second part of the report is a description of the experimental procedure. It includes the materials, the apparatus, and the procedure. The materials are hydrogen peroxide, potassium iodate, and a catalyst. The apparatus is a reaction vessel, a thermometer, and a stopwatch. The procedure is as follows: a solution of potassium iodate is prepared in a reaction vessel. A solution of hydrogen peroxide is added to the reaction vessel. The reaction is started by adding a catalyst. The time taken for the reaction to complete is measured with a stopwatch. The temperature of the reaction mixture is measured with a thermometer.

3. The third part of the report is a description of the results. It includes the data, the graphs, and the conclusions. The data is as follows: the rate of reaction is measured at different temperatures. The graphs are plots of the rate of reaction against temperature. The conclusions are that the rate of reaction increases with temperature and that the activation energy of the reaction is 40 kJ/mol.

CHIEF

COLL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 2 should be detached for use as the burial-transit permit. Then please remove corroborators. Pages 1 and 2 should be filed with the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

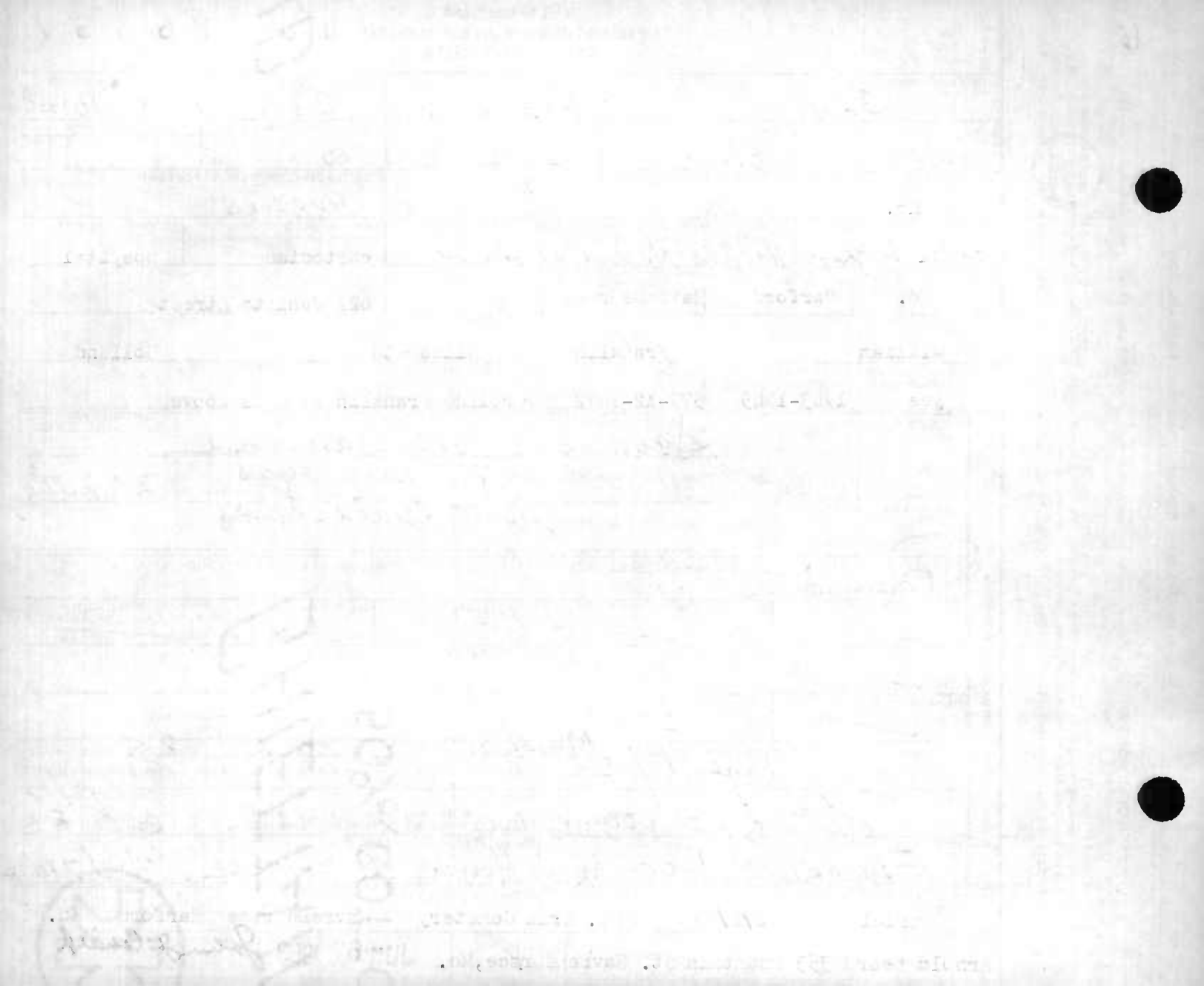
8 3 1 6 3 5 7

FOR
1 - STATE
REGISTRAR

REG. NO.

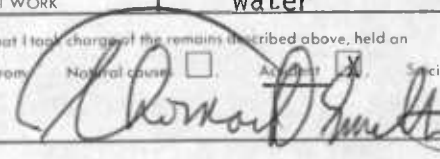

1. DECEASED NAME (TYPE OR PRINT) JAMES FRANKLIN			2a. DATE OF DEATH MONTH DAY YEAR June 1 83			2b. HOUR 10:22 A.				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 14 23		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 10 22		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.				
11. CITY OR TOWN OF DEATH HAVERDE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) custodian		12b. KIND OF BUSINESS OR INDUSTRY hospital		
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN HavreDeGrace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William Franklin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Holland			16. STREET ADDRESS 822 Juniata Street 21078				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 1943-1945 579-12-9472		17. INFORMANT Jeroline Franklin same as above				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of the Esophagus with Metastasis DUE TO, OR AS A CONSEQUENCE OF (b) 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from March 26 1983 to June 1 1983 , that (I) (we) lost saw the deceased alive on June 1, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward C. Loo, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/1/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.			22e. ADDRESS Havre de Grace, Md. 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/4/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE HavreDeGrace Harford Md.			
24. FUNERAL DIRECTOR NAME Arnold Beard 353 Fountain St. HavreDeGrace, Md.			ADDRESS HavreDeGrace, Md.			25a. DATE REC'D. BY REGISTRAR JUN 6 1983				

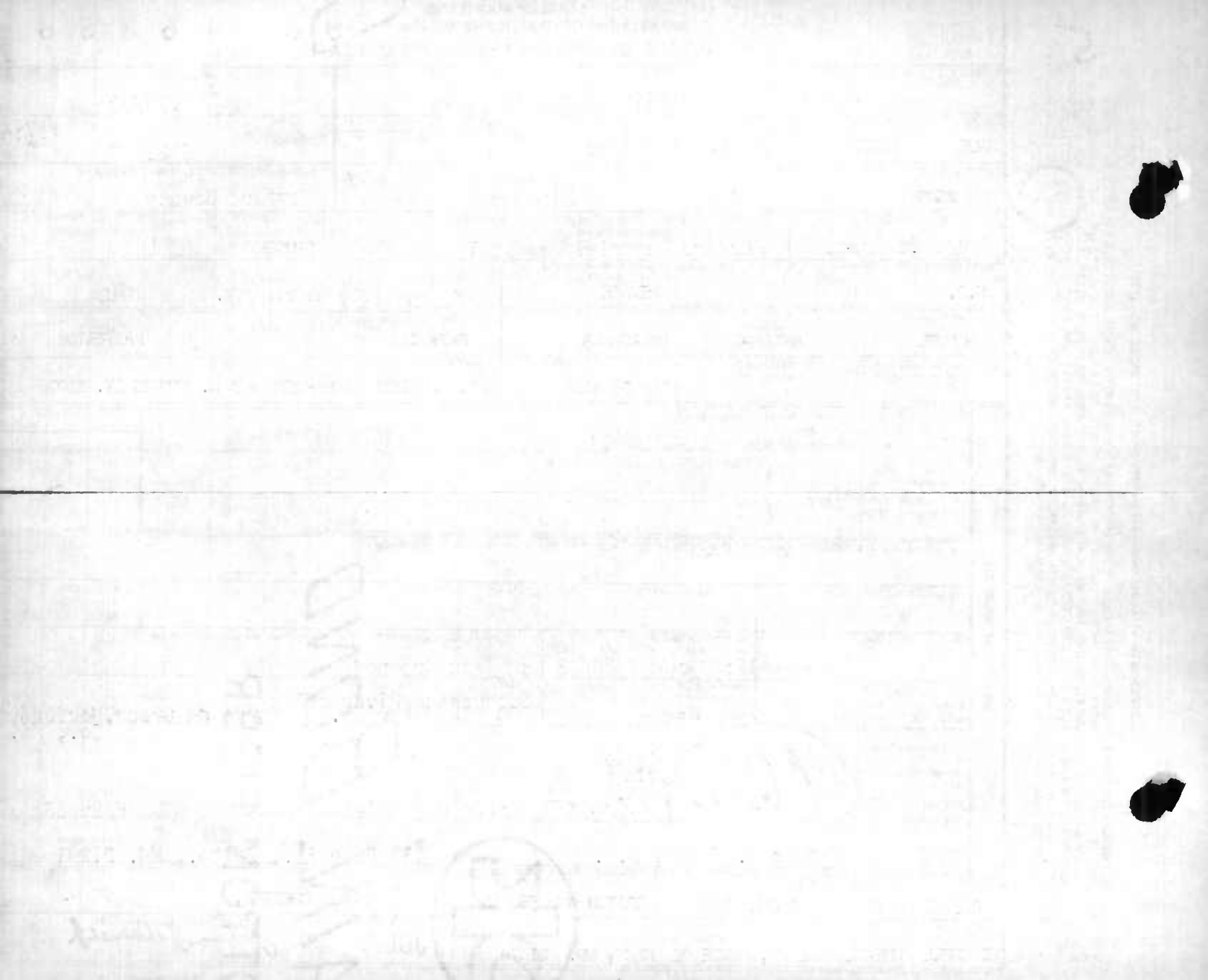
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. RESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16358	
1. DECEASED NAME (TYPE OR PRINT) James William Galagarza							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6/28/83		2b. HOUR M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05 19 1966		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 6/28/83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		2d. HOUR 2:10 P	
10. CITY OR TOWN OF DEATH Harve de Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE N.J.		13b. COUNTY		13c. CITY OR TOWN NEWARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 37 1/2 WAKEMAN AVE.		07104	
14. FATHER'S NAME FIRST MIDDLE LAST MANUEL ANTIANO GALAGARZA						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATRICIA MASTERTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 219 78 4856		17. INFORMANT ADDRESS MRS. PATRICIA WAGENFUEHR 425 N. STOKES ST. 21078					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9109 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:00 Noon 6/28/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION CITY OR TOWN COUNTY STATE Susquehanna River off Harve de Grace, Harford Co., Md.					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 6/29/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1 JULY 1983		23c. NAME OF CEMETERY OR CREMATORY CRATIN AND FERRIS				23d. LOCATION CITY OR TOWN COUNTY STATE WEST CHESTER, PENN.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR JUL 5 1983		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 6 3 5 9	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) William Lawrence Hardy						2a. DATE OF DEATH MONTH DAY YEAR June 6, 1983		2b. HOUR 9:15 PM			
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3/24/03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Consolidated			
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Fallston, Md. Eng. 2001 Carrs Mill Rd. 21047		
14. FATHER'S NAME FIRST MIDDLE LAST William Trimble Hardy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Louise Timmons							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 4292		17. INFORMANT Mrs. Alice Hardy, Fallston, Md. 21047		ADDRESS 2001 Carrs Mill Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD & Congestive Heart failure few years DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson's Disease few years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Less than 1 hr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cancer of the Throat											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from April 19 83 , to May 19 83 , that (I) (we) last saw the deceased alive on June 6 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Perfecto L. Valarao				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-7-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PERFECTO L. VALARAO				22e. ADDRESS 1716 HARFORD ROAD, FALLSTON MD 21047							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-9-1983		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md.					
24. FUNERAL DIRECTOR E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087				25a. DATE REC'D. BY REGISTRAR JUN 13 1983		25b. REGISTRAR'S SIGNATURE John J. Connel					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be completed and a medical certification completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 1 6 3 6 0			
1- FOR STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JEFFERY CHARLES HEAD					2a. DATE OF DEATH MONTH DAY YEAR 06-09-83			
3. SEX MALE					2b. HOUR 1:45 P.M.			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 20 67		6. AGE (IN YEARS LAST BIRTHDAY) 15		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD		
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY HARFORD CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 135 KELLY AVENUE				
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES LESTER HEAD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth CORINA Elliott		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 214-86-3655		17. INFORMANT ADDRESS CHARLES HEAD 135 KELLY AVENUE, BEL AIR, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain death 8199 DUE TO, OR AS A CONSEQUENCE OF (b) Severe compound depressed skull DUE TO, OR AS A CONSEQUENCE OF (c) Rx = (D) full contusion + hematoma				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION 5/25/83, 6/6/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (b) abn + 8 to relieve T1CP		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-29 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Auto Accident				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Shafter Shop Rd.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bel Air Harford Co. Maryland		22a. I certify that (I) (this hospital) attended the deceased from 5/29/83 , 19 83 , to 6/9 , 19 83 , that (I) (we) last saw the deceased alive on 6/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.		
22b. SIGNATURE Paranitis J. Sclero		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JUNE 9, 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. L. SITA RDS MD		22e. ADDRESS 1874 BELAIR RD FALLSTON MD 21047		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				
23b. DATE JUNE 11, 1983		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014				
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR JUN 13 1983		25b. REGISTRAR'S SIGNATURE John J. Smith		

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 6 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN NAOMI HILLMAN			2b. DATE OF DEATH MONTH DAY YEAR JUNE 16, 1983		2c. HOUR 2¹⁵ P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 19, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) BELLE PLAINE, IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY HARFORD		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. England		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Patton		16. STREET ADDRESS 102 IDLEWILD STREET 21014			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 485.10.7743D		17. INFORMANT DAVID A. HILLMAN		17. ADDRESS 27 HUNTINGTON PLACE BEL AIR, MARYLAND 21014	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cancer of Pancreas**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Diabetes Mellitus

19a. DATE OF OPERATION 6/16/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes Mellitus		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/16/83 to 6/17/83 , that (I) (we) last saw the deceased alive on 6/16/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Jesaiah		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-17-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. JESAYAH, M.D.		22e. ADDRESS 433 Girard St, Harv de Gray, Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6/17/1983		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222				25a. DATE REC'D. BY REGISTRAR JUN 21 1983			
				25b. REGISTRAR'S SIGNATURE John J. Connel			

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CHATELAIN

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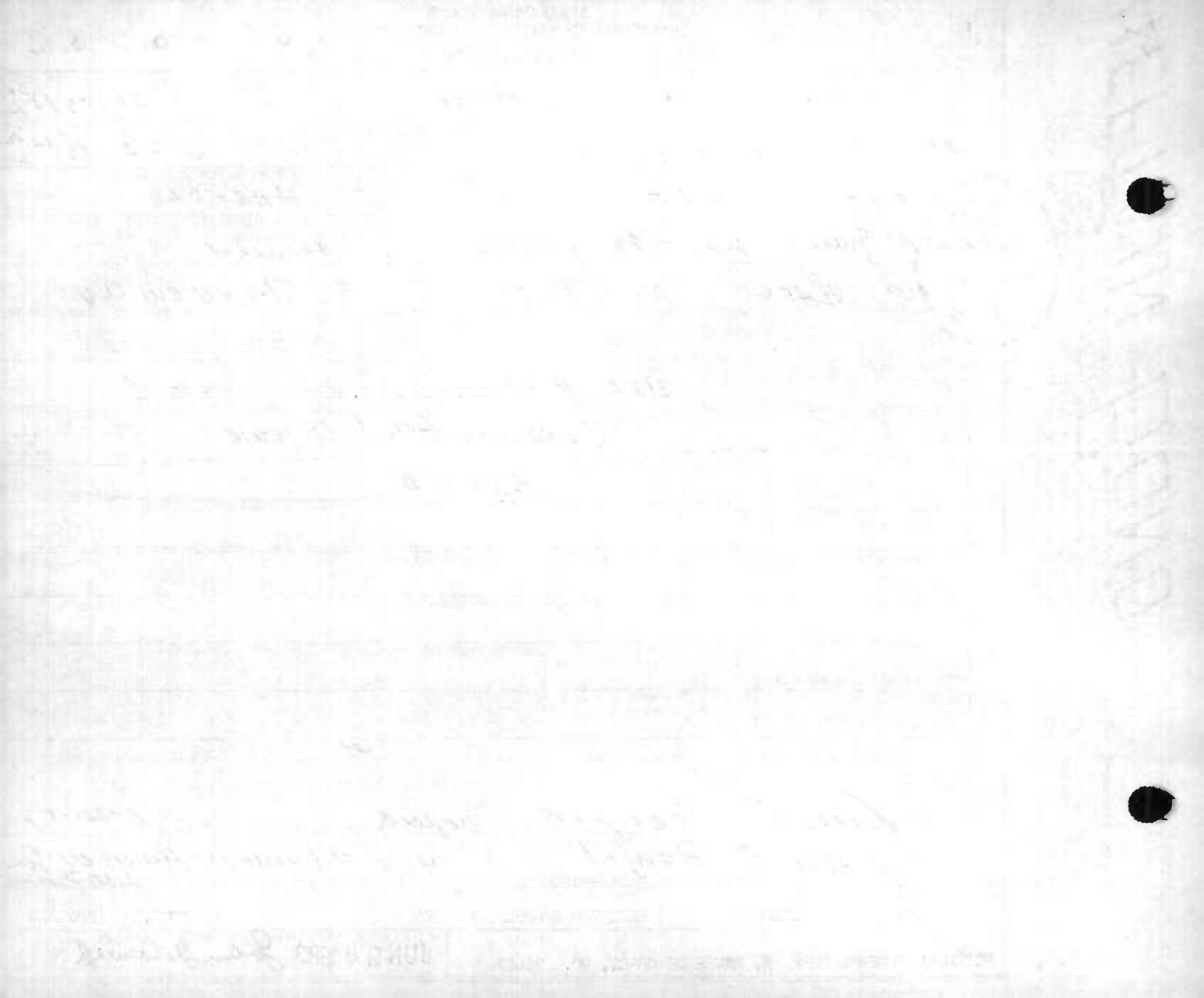


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6362	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilmer B Hines										2b. HOUR 12:36 PM	
2. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 2 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 6 22 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md				13b. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 22 Clearview av 21901			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN B. HINES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ANN LOUISE CLARK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-01 8843		17. INFORMANT ADDRESS MRS. BLANCHE E. HINES SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF ASCVD (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E Benjel				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED 6-22-83	
EXAMINER'S NAME (TYPE OR PRINT) Luis E Benjel				ADDRESS 464 Ellamont St Havre de Grace 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 25JUNE83		23c. NAME OF CEMETERY OR CREMATORY WESLEYAN CHAPEL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD, MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR JUN 28 1983		25b. REGISTRAR'S SIGNATURE John J. Carroll			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DANIEL F. HOZFLER			2a. DATE OF DEATH MONTH DAY YEAR JUNE 14, 1983		2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN. 27, 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 62	IF UNDER 1 YEAR IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH JARRETTSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1416 BALDWIN MILL ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRILL PRESS		12b. KIND OF BUSINESS OR INDUSTRY KOPPER'S CO.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY HARFORD	13c. CITY OR TOWN JARRETTSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST FRANK HOZFLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN PIASECKI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII		16b. SOCIAL SECURITY NO. 218 05 7223		17. INFORMANT ADDRESS FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 1541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA, RECTUM DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 MOS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCT 31 , 19 81 , to JUNE 14 , 19 83 , that (I) (we) last saw the deceased alive on JUNE 14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 2:45 PM					
22b. SIGNATURE Benedict S. Garin		DEGREE		22c. DATE SIGNED 6/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BENEDICTO S. GARIN		22e. ADDRESS 2406 BALDWIN MILL ROAD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 18, 1983		23c. NAME OF CEMETERY OR CREMATORY BELAIR MEM. GAR.	
23d. LOCATION CITY OR TOWN COUNTY STATE BELAIR HARFORD MARYLAND		23e. DATE REC'D. BY REGISTRAR JUN 27 1983			
24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL		ADDRESS 8800 HARFORD RD.		25a. DATE REC'D. BY REGISTRAR JUN 27 1983	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 99563-444

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIANNE HOFFMAN			2a. DATE OF DEATH MONTH DAY YEAR June 26 1983			2b. HOUR 7:15 PM			
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4/21/97		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CZECHOSLOVAKIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY HARFORD		13c. CITY OR TOWN JOPPA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN MADER			15. MOTHER'S MAIDEN NAME FIRST LAST EVA KREINHOEFNER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 78166022A			17. INFORMANT ADDRESS WALTER HOFFMANN 580 TRIMBLE ROAD						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4/49 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe End Stage CAD DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
CAD, Ischemic Cardio myopathy

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/20 , 19 83 , to 6/26 , 19 83 , that (I) (we) last saw the deceased alive 6/26 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. J.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR M.D.		22e. ADDRESS 1716 Harford Road.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-29-83		23c. NAME OF CEMETERY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND	
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24. FUNERAL DIRECTOR NAME [Signature]		25a. DATE REC'D. BY REGISTRAR JUN 28 1983		25b. REGISTRAR'S SIGNATURE [Signature]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME		2a. DATE OF DEATH		2b. HOUR	
FIRST	MIDDLE	MONTH	DAY	YEAR	
Franklin	Benjamin	6	7	83	12:15 PM
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		MONTH April 22, 1922	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
Md. U.S.A.		U.S.A.		61 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Fallston		FALLSTON General		HARFORD MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Ret. Disabled Vet.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Harford		Bel air	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Henry		Emma		Eckerd	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		2nd. W.W.		Mary E. Lom	
		213-18-3151		639 Rowland Rd. Port Deposit, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) wide spread Pul. Met. 2° Hypertrophies					
DUE TO, OR AS A CONSEQUENCE OF (b) 8 Lt kidney					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure					
DUE TO, OR AS A CONSEQUENCE OF (c) Lt. lower lobe pneumonia					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOV 11, 1982, to 6-7-1983, that (I) (we) last saw the deceased alive on 6-7-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
MURLI MATHUR MD		MD		6.7.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MURLI MATHUR MD		1305 Fallston Rd. Fallston Md 21049			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6-10-1983		New Bridge Baptist Cen. Colora	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Richard L. Goodie ADDRESS: Rising Sun, Md.		JUN 10 1983		John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH (6/21/83)		8 3 1 6 3 6 6	
FOR STATE REGISTRAR <u>Harry Edward Hopkins, Sr.</u>		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST <u>HARRY Edward HOPKINS, Sr.</u>		MONTH DAY YEAR <u>JUNE 21, 1983</u>		HOUR MIN. <u>9 55</u> M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
<u>Male</u>	<u>White</u>	MONTH DAY YEAR <u>May 10, 1898</u>	<u>85</u> YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH (<u>Hartford Co.</u>)		
<u>Maryland</u>	<u>U.S.A.</u>		<u>HARTFORD</u> MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
<u>FALLSTON</u>	<u>FALLSTON GEN. HOSPITAL</u>		<u>HEAVY Equip. Operator</u>		<u>County Highway Dept.</u>
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
<u>Md.</u>		<u>HARTFORD</u>	<u>BEL AIR</u>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<u>13 South REED Street</u> <u>21014</u>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST <u>George Alfred Hopkins</u>		FIRST MIDDLE LAST <u>Mary Elizabeth Foreman</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Last, first, middle) ADDRESS	
<u>YES-Army</u>		<u>W.W. 1</u>		<u>Mrs. Wilhelmina H. Ellis</u> <u>1585 Jarrettville Road</u> <u>Jarrettville, Maryland 21084</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cardiac arrest w/ arrhythmia</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE art. sclero. cerebrovas. dis.</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis generalized</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
<u>—</u>		<u>—</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
<u>—</u>		HOUR A.M. MONTH DAY YEAR <u>— P.M. 19</u>		<u>—</u>	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		<u>—</u>		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 11 19 71</u> to <u>JUNE 21 19 83</u> , that (I) (we) last saw the deceased alive on <u>JUNE 6 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>BEN OTEY ZA</u>		<u>M.D.</u>		<u>6/21/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>BEN OTEY ZA, M.D.</u>		<u>1131 BALTIMORE PIKE BEL AIR, Md. 21014</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
<u>Burial</u>		<u>JUNE 23, 1983</u>	<u>BEL AIR MEMORIAL GARDENS</u>		CITY OR TOWN COUNTY STATE <u>BEL AIR, Hartford Co., Maryland 21014</u>
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Joseph William Foster</u> <u>W. Broadway & Williams St.</u> <u>BEL AIR, Maryland 21014</u>		<u>JUN 23 1983</u>		<u>John J. Conner</u>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16367	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY NANN JACKSON										2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 6-19-83	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 12 26 08	6. AGE (IN YEARS MONTH DAY YRS. 82	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD 6-21-83		2b. HOUR 3			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH ABERDEEN		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 127 CHANOVER ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN ABERDEEN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 127 CHANOVER ST #2104			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Jackson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 324-05-3263		17. INFORMANT ADDRESS Gladys Brown 127D Hanover St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) ASCUD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE L. Rempel				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 6/21/83			
EXAMINER'S NAME (TYPE OR PRINT) LUISE R. RENTEL, MD				ADDRESS 4640 LIANKE ST. H D G.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/27/83		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace Harford Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Arnold Beard 353 Fountain St. HavreDeGrace, Md.						25a. DATE REC'D. BY REGISTRAR JUN 29 1983		25b. REGISTRAR'S SIGNATURE Joan J. Canine			

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UNUS & BROS. of New York

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Walter Eugene Jackson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 4, 1983</i>			2b. HOUR <i>10:50 PM</i>	
3. SEX <i>male</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>SEPT 29, 1911</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>DEL</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i> MD.				
10. CITY OR TOWN OF DEATH <i>HAVRE DE GRACE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD Memorial Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>(RET) SUPERVISOR</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>BG & E</i>
13a. STATE <i>MD</i>			13b. COUNTY <i>HARFORD</i>	13c. CITY OR TOWN <i>HAVRE DE GRACE</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>415 SOUTH UNION AVE. 21078</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>WILLIAM ANDREW JACKSON</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ETHEL STOTSENBERG HULETT</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212 05 4934A</i>		17. INFORMANT ADDRESS <i>Mrs. Virginia E. Jackson Same As #13e</i>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4149

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>April 13, 1982</i> to <i>May 18, 1982</i> , that (I) (we) lost saw the deceased alive on <i>5-18-82</i> 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <i>M. S. Sharaf El-Deane, MD</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. S. SHARAF EL-DEANE, MD</i>	22e. ADDRESS <i>P.O. Box 935 Edgewood, Md 21040</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>7 JUNE 83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL CEMETERY</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>HAVRE DE GRACE, HARFORD, MD.</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 8 1983</i>	
		25b. REGISTRAR'S SIGNATURE <i>John E. C... ..</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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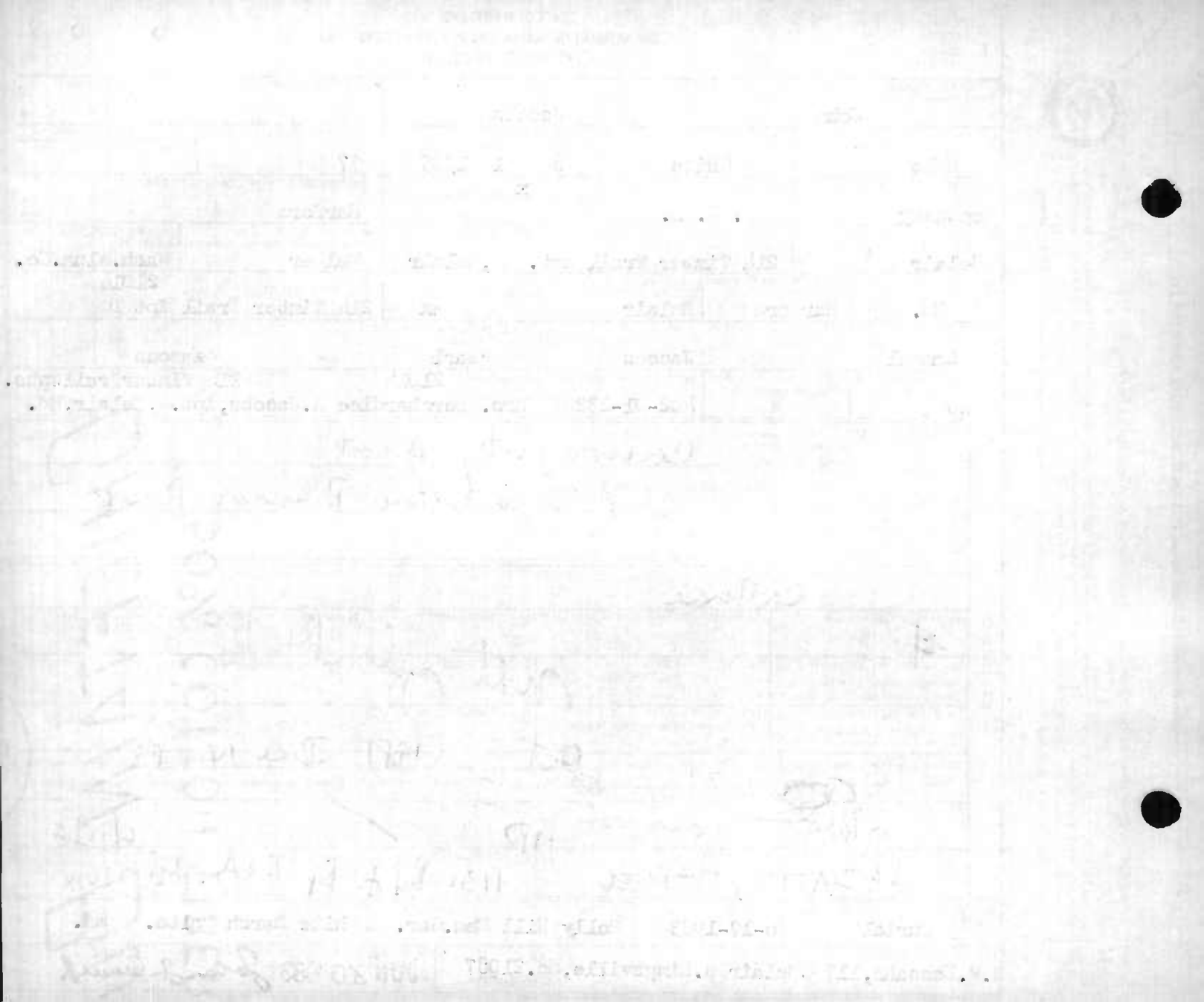
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				8 3 1 6 3 6 9			
1. DECEASED NAME (TYPE OR PRINT) John Jacobs				2a. DATE OF DEATH MONTH DAY YEAR 6 14 83 2b. HOUR 7:00 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 1 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Belair		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 214 Timber Trail Apt. D, Belair		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY Wash. Alum. Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Belair		13e. STREET ADDRESS 214 Timber Trail Apt D	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Jacobs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Sammons			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 402-01-2320A		17. INFORMANT 21014 Mrs. Bernhardine A. Jacobs, Apt. D, Belair, Md.		ADDRESS 214 Timber Trail Apts.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cathexis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION Oct 19 1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestine		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 1981		21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) P.M.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1131 Bel Air Rd Bel Air Md 21014			
22a. I certify that (I) (this hospital) attended the deceased from Oct 19 1981, to June 14 1983, that (I) (we) lost saw the deceased above, (I) (we) saw the body after death.							
22b. SIGNATURE M. J. Lazatin		22c. DATE SIGNED 4/15/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZATIN, MAMMA		22e. ADDRESS 1131 Bel Air Rd Bel Air Md 21014	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-17-1983		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Balto. Md.	
24. FUNERAL DIRECTOR E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087				25a. DATE REC'D. BY REGISTRAR JUN 20 1983			
				25b. REGISTRAR'S SIGNATURE John J. Conner			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 7 0

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK EMIL JANDA			2a. DATE OF DEATH MONTH DAY YEAR 06 24 83		2b. HOUR 7:55 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05 07 15		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHEET METAL MECH	
13a. STATE MD.		13b. CITY OR TOWN BALTO. KINGSVILLE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 6613 MOUNT VISTA ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD JANDA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA MARES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 21 7-05-5744		17. INFORMANT ADDRESS DOORIS JANDA 6613 MT. VISTA RD. KINGVILLE MD. #31087			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary failure 5315 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis (generalized infection) and metastatic lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) metastatic		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 weeks	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Peptic ulcer disease with perforation and peritonitis

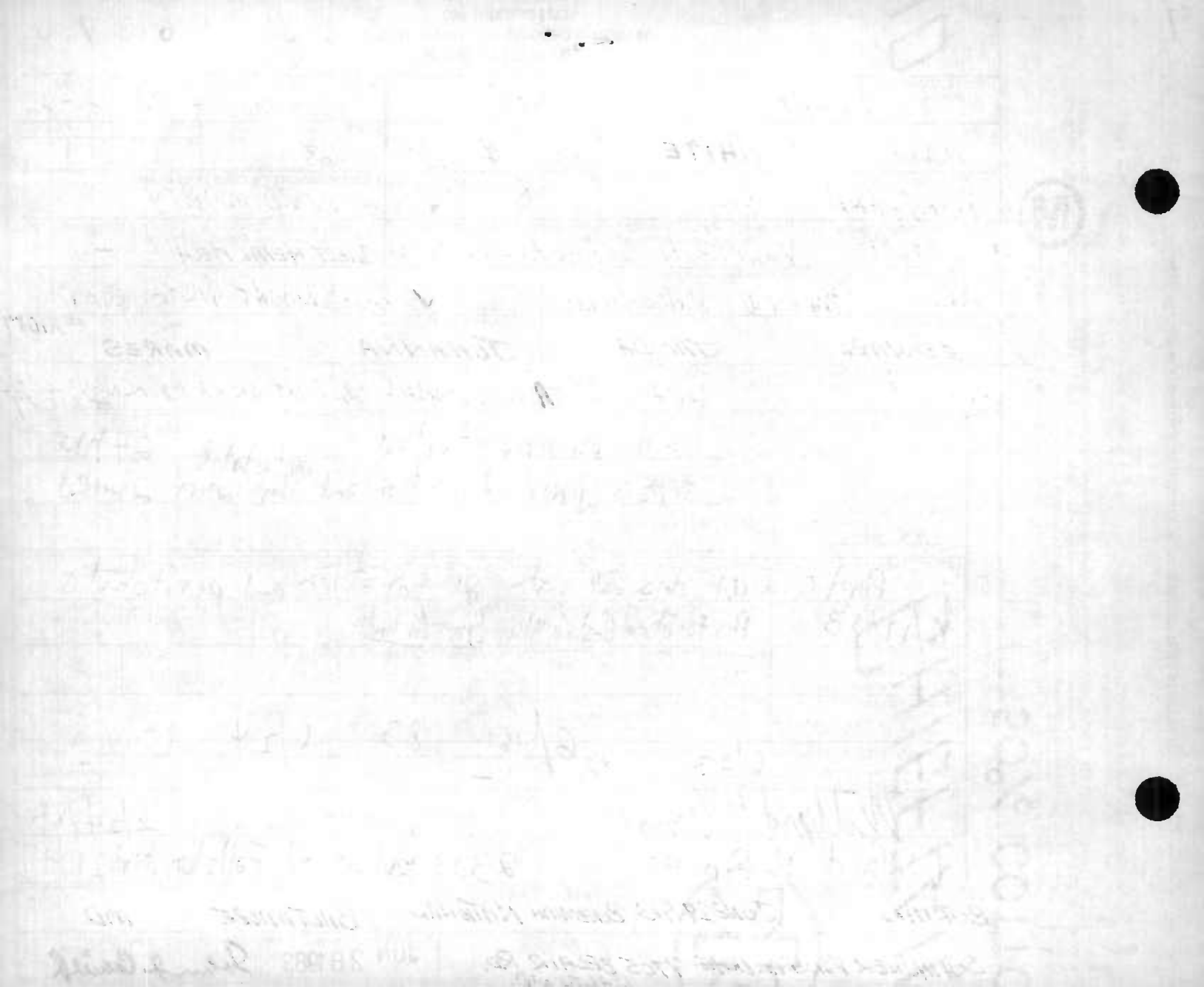
19a. DATE OF OPERATION 6/17/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Gastric Ulcer Peritonitis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/16 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 6/24 83			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6/24 83		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) 2303 Belair Rd, Fallston, MD			
22a. I certify that (I) (this hospital) attended the deceased from 6/23 83 to 6/24 83 , that (I) (we) last saw the deceased alive on 6/23 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Willard P. Amoss				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 6/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amoss				22e. ADDRESS 2303 Belair Rd, Fallston, MD 21047			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE JUNE 27 1983		23c. NAME OF CEMETERY OR CREMATORY BEHEMION NATIONAL		23d. LOCATION (CITY OR TOWN COUNTY STATE) BALTIMORE MD	
24. FUNERAL DIRECTOR (NAME ADDRESS) SCHMIDTKE FUNERAL HOME 9705 BELAIR RD. BALTO. MD				25a. DATE REC'D. BY REGISTRAR JUN 28 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8316371	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Marco Antonio Montalvo		FIRST Jimenez, Jr.		MIDDLE Jimenez, Jr.		LAST Jimenez, Jr.		2a. DATE OF DEATH MONTH DAY YEAR June 6, 1983		2b. HOUR 8:30 A.M.	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1983		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 3 22		IF UNDER 1 YEAR MONTHS DAYS 3 22		IF UNDER 24 HRS. HOURS MIN. 3 22	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Harford A.P.G.		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 2733 Watervliet St., 21005							
14. FATHER'S NAME FIRST MIDDLE LAST MARCO Jimenez		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Louise Landreth		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO							
16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Marco A.M. Jimenez, Sr. A.P.G., MD 21005									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7650 Prematurity (25 weeks gestation) and Cardiopulmonary arrest.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: g											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6-6 , 19 83 , to 6-6 , 19 83 , that (I) (we) last saw the deceased alive on 6-6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chul Hong Kim		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/6/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chul Hong Kim		22e. ADDRESS 114 W. Bell Ave, Aberdeen, Md 21001									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 8, 1983		23c. NAME OF CEMETERY OR CREMATORY Cratin and Ferris		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester PA					
24. FUNERAL DIRECTOR NAME ADDRESS Farring Funeral Home, P.A., Aberdeen, MD, 21001-3399		25a. DATE REC'D. BY REGISTRAR JUN 9 1983									
25b. REGISTRAR'S SIGNATURE Joan Z. Conner											

Handwritten notes and stamps on lined paper, including a date stamp 'JAN 1950' and a signature 'J. Edgar Hoover'.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3

1 6 3 7 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alexander Jones			2a. DATE OF DEATH MONTH DAY YEAR June 6, 1983		2b. HOUR 7:45 A^M
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 1 28 34		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled	12b. KIND OF BUSINESS OR INDUSTRY Gov't
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Havre De Grace	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1227 Battery Drive 21078
14. FATHER'S NAME FIRST MIDDLE LAST George Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Snowden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 215-32-3344		17. INFORMANT LaJuene Jones same as above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory insufficiency**
 1629
 DUE TO, OR AS A CONSEQUENCE OF
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
 (b) **Carcinoma of lung**
 DUE TO, OR AS A CONSEQUENCE OF
 (c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/30/ 19 83 , to 6/6 19 83 , that (I) (we) last saw the deceased alive on 6/6 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 6/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) I.D. SUMMERVILLE		22e. ADDRESS 400 LEWIS ST HAVRE DE GRACE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	

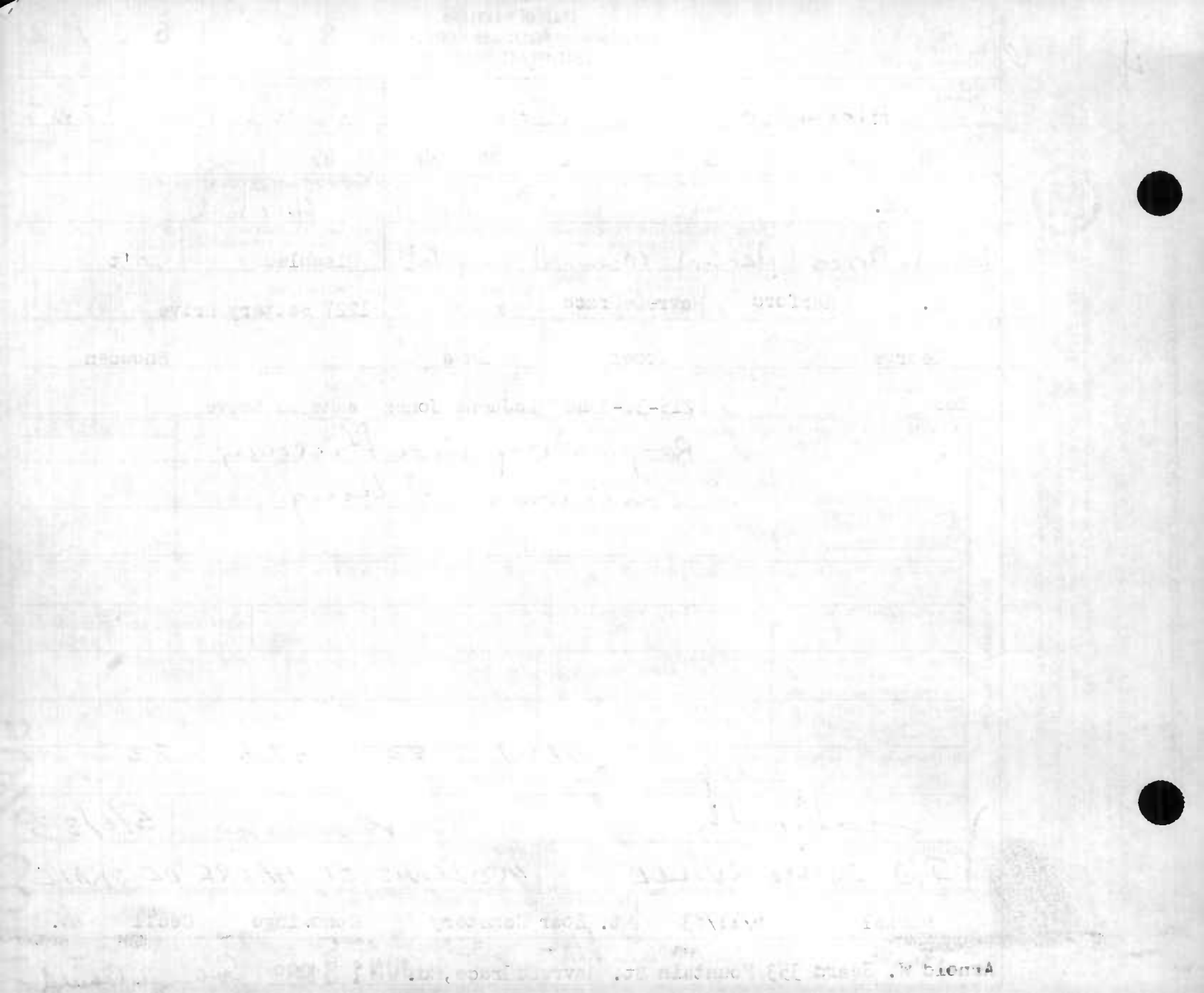
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/11/83	23c. NAME OF CEMETERY OR CREMATORY Mt. Zoar Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Conowingo Cecil Md.
24. FUNERAL DIRECTOR NAME ADDRESS Arnold W. Beard 353 Fountain St. Havre De Grace, Md.		25a. DATE REC'D. BY REGISTRAR JUN 13 1983	25b. REGISTRAR'S SIGNATURE [Signature]

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 1 6 3 7 3	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) GLADYS MAE Jones										2a. DATE KNOWN OF DEATH MONTH 6 DAY 17 YEAR 1983	
3. SEX F 4. RACE B 5. DATE OF BIRTH MONTH 5 DAY 25 YEAR 28 6. AGE (IN YEARS) LAST MONTH 35 YRS.										2c. DATE PRONOUNCED DEAD MONTH 6 DAY 17 YEAR 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina										7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD CO.	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -	
13a. CITY OR TOWN BALTIMORE										13b. STREET ADDRESS 550 McMechen Street 21217	
14. FATHER'S NAME FIRST Thomas MIDDLE Anderson LAST Anderson										15. MOTHER'S MAIDEN NAME FIRST Luvenia MIDDLE Pyles LAST Pyles	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. 216-32-1935	
17. INFORMANT Herman Jones										ADDRESS 550 McMechen Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF ASCVD DUE TO, OR AS A CONSEQUENCE OF ASCVD DUE TO, OR AS A CONSEQUENCE OF ASCVD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E Renjel M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 6-17-83	
EXAMINER'S NAME (TYPE OR PRINT) LUIS E RENJEL MD ADDRESS 464 Alliance St Harford Co										23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	
23b. DATE 6/23/83										23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Glenburnie Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE 21075											
24. FUNERAL DIRECTOR NAME Wm C March ADDRESS F/H Inc. 1101 E North Ave.										25a. DATE REC'D. BY REGISTRAR JUN 20 1983	
25b. REGISTRAR'S SIGNATURE John J. Carver											

BOX BOTTOM LID

HELEN M. DOWD

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

3000 0 5000

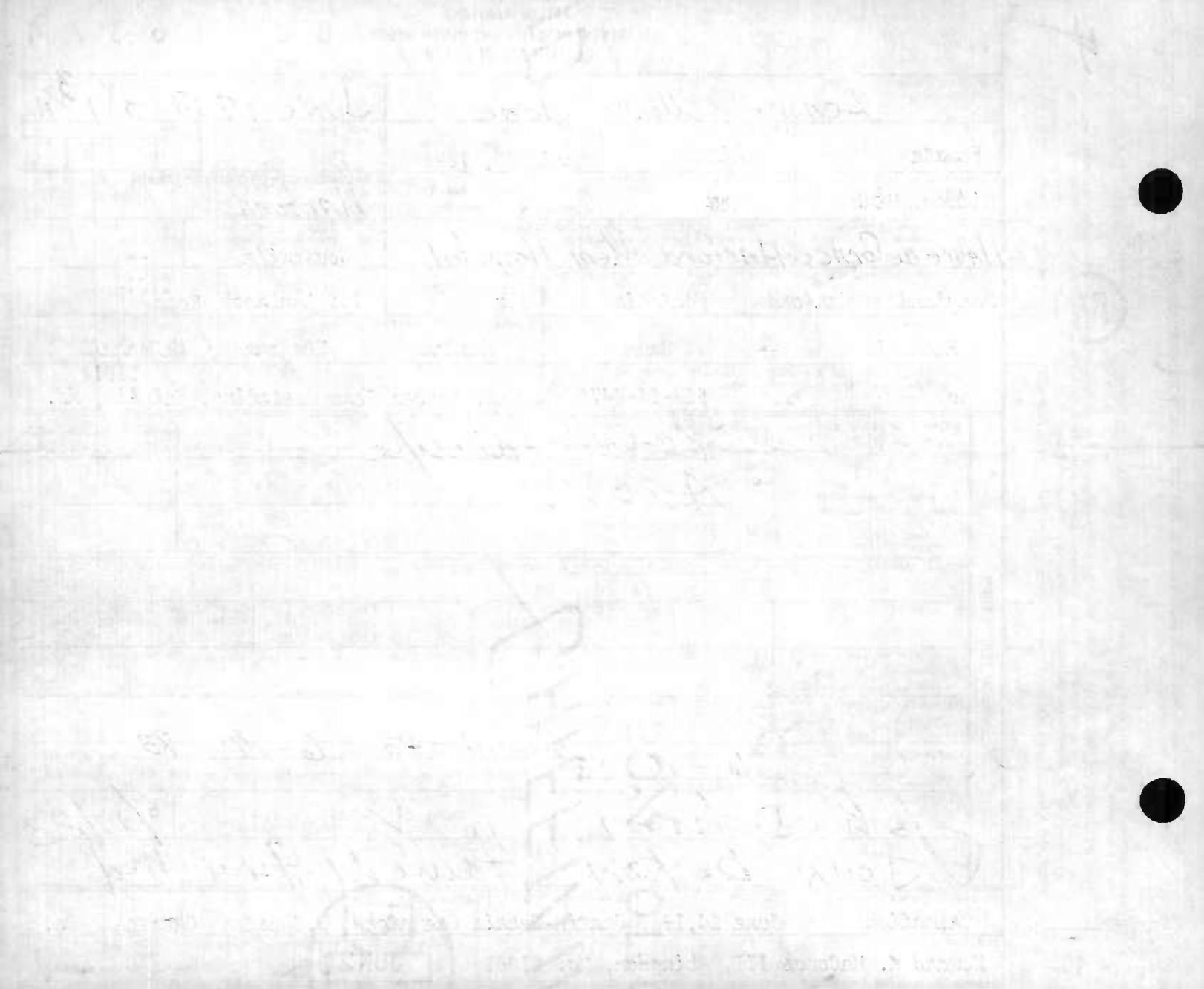
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 16374			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR 2b HO			
1. DECEASED NAME FIRST MIDDLE LAST <i>Lenore Wardle Jones</i>				June 17 1983 12 ³⁵ AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 30, 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 85	
7a. BIRTHPLACE (STATE OR FOREIGN) Midway, Utah		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin -- Baum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Elenore McCarrell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --		16b. SOCIAL SECURITY NO. 528-58-4470	
17. INFORMANT ADDRESS Mrs. Lenore Jean Hesseling, Bel Air, Md.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-14-83</i> to <i>6-17-83</i> , that (I) (we) last saw the deceased alive on <i>6-17-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John D. Yun</i>		DEGREE		22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN		22d. ADDRESS Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 20, 1983		23c. NAME OF CEMETERY OR CREMATORY Cratin-Ferris Crematory, W. Chester		23d. LOCATION CITY OR TOWN COUNTY STATE Chester Pa.	
24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JUN 20 1983		25b. REGISTRAR'S SIGNATURE <i>Joan J. Conner</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 6 3 7 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mary Etcelle Jones				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 06 18 83 325 P M			
3 SEX female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09 13 93		6. AGE (IN YEARS LAST BIRTHDAY) X 86 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY B & O. R. R.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13e. STREET ADDRESS 327 McCann St. 21040	
14. FATHER'S NAME FIRST MIDDLE LAST William Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie A. Ball			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705 10 0105		17. INFORMANT ADDRESS Mr. Thomas P. Jones Edgewood, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: CARDIO PULMONARY ARREST IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOCTORS HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) 2 WEEKS YEARS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/18 19 83 , to 6/18 19 83 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Baron A. Wohl MD.				DEGREE ATTENDING MEDICAL <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARON A. WOHL				22e. ADDRESS 2303 BELAIR RD FAUSTON MD 21047			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/21/83		23c. NAME OF CEMETERY OR CREMATORY White Stone Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE White Stone, Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Elmore-Haynie Funerl Home Kilmarnock, Va.				25a. DATE REC'D. BY REGISTRAR JUN 23 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield	

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Official

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Its title

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

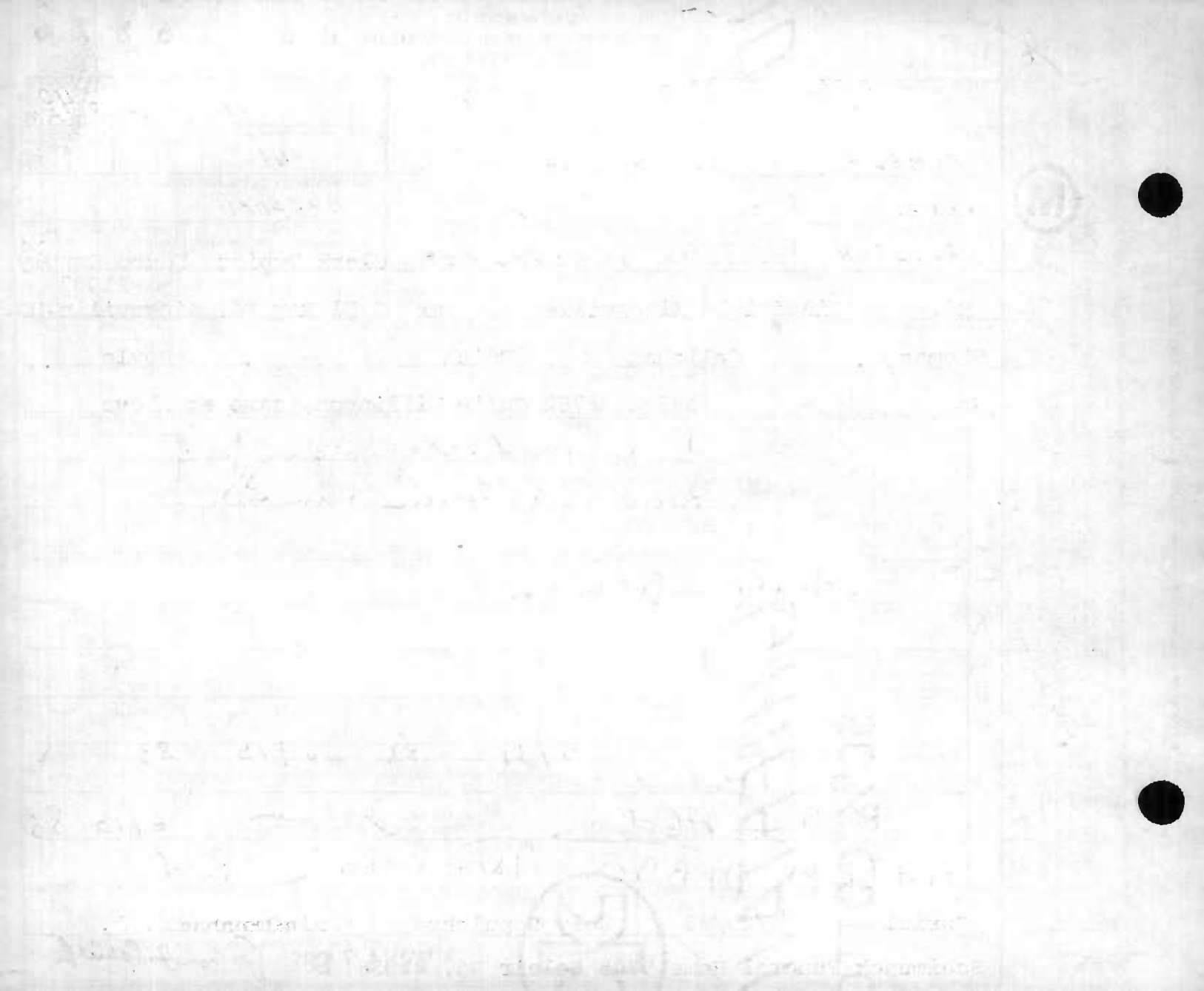
8 3 1 6 3 7 6

1. FOR
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JULE ELIZABETH KENNEDY				2a. DATE OF DEATH MONTH DAY YEAR 04 15 83		2b. HOUR 3 40 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 04 28 1922		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 61	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Typist		12b. KIND OF BUSINESS OR INDUSTRY Eddco Supply	
13a. STATE Md.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 21087 9 El Ray Rd, Kingsville, Md.	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Callahan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Boyle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			
17. SOCIAL SECURITY NO. 195-20-8752		17. INFORMANT Julie Wilkinson, same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent brain tumor DUE TO, OR AS A CONSEQUENCE OF (c) Scalp infection							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/31 , 19 83 , to 6/15 , 19 83 , that (I) (we) lost saw the deceased alive on 6/14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE HATEM		DEGREE ABDO.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HATEM		22e. ADDRESS 1814 Belair Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/83		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, PA.	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home				ADDRESS 9705 Belair Rd,		25a. DATE REC'D. BY REGISTRAR JUN 17 1983	
				25b. REGISTRAR'S SIGNATURE John J. Conish			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 7 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glai Carlson Kilby			2a. DATE OF DEATH MONTH DAY YEAR June 5 83		2b. HOUR 2¹⁵ PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 2, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH HAUGS & GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp 21078		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Churchville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Churchville, MD 2830 Medical Hall Road 21028	
14. FATHER'S NAME FIRST MIDDLE LAST Charles B. Kilby			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maxie Lee Koontz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-05-3891		17. INFORMANT ADDRESS Dana R. Kilby 2830 Medical Hall Road Churchville, Md 21028	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) EXTENSIVE MYOCARDIAL INFARCTION (c) ARTERIOSCLEROSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/5/83 19 83 , to 6/5 19 83 , that (I) (we) last saw the deceased alive on 6/5 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dante Monakil DEGREE				22c. DATE SIGNED 6/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL				22e. ADDRESS 6225 Union Ave Harford, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 8, 1983		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gdns.	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A. 333 S. Parke 21001-3399		24b. ADDRESS Aberdeen, MD		25a. DATE REC'D. BY REGISTRAR'S SIGNATURE JUN 9 1983	
23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland					

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22-10-2-1950

June 2, 1950

4-7-50

Mr. J. H. ...

Mr. J. H. ...

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

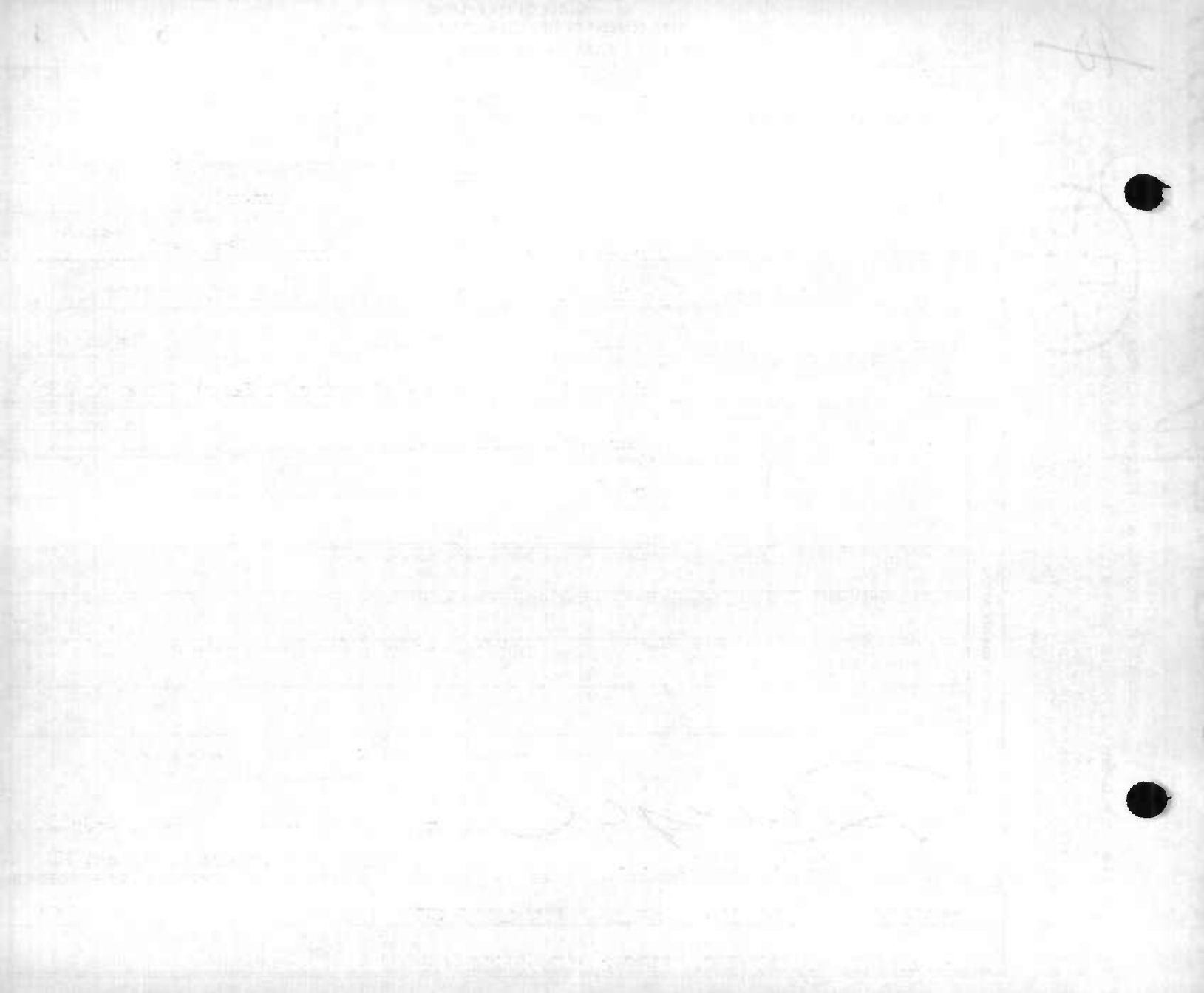
1. DECEASED NAME (TYPE OR PRINT) Robert NMI Lems			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 6 3 19 83			2b. HOUR 5A			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 18 09	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-3 19 83			2d. HOUR 7:30
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 623 Weatherby Rd. 21014				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired (Butcher)		12b. KIND OF BUSINESS OR INDUSTRY Meat Processor	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7726 Gough St. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST George Lems			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Reges						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-01-1826		17. INFORMANT ADDRESS Wife (Catherine M. Lems) (Same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 15 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Luis E. Renjel</i>			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER		DATE SIGNED 6-3-83	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.			ADDRESS 464 Alliance St. Havre De Grace, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6/4/1983		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC.			ADDRESS DUNDALK, MD. 21222			25a. DATE REC'D. BY REGISTRAR JUN 7 1983		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (1))
15M2/80

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 6 3 7 9	
FOR 1 - STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rhoda Elsie Linton					2a. DATE OF DEATH MONTH DAY YEAR June 30 1983				2b. HOUR 10 ⁰⁸ PM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 16 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 55 Rolling Hills Ranch Rd. 21904			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph D. Meck				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda Barnes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-26-4536		17. INFORMANT Paul N. Linton, Sr. Port Deposit, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Cardiac Arrest - Acute Myo-cardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S. C.V.D. and Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes mellitus, C.O.P.D. - by history</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1983</u> to <u>June 30, 1983</u> , that (I) (we) lost saw the deceased alive on <u>June 30, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Edward C. Loo, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/30/83.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.				22e. ADDRESS Harford de Grace, Md. 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 5, 1983		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 12 1983							
				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 8 3 1 6 3 8 0					
1. DECEASED NAME (TYPE OR PRINT) John Nick Markline Jr.					2a. DATE OF DEATH MONTH DAY YEAR June 14, 1983			2b. HOUR 7:40 pm		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 24, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
10. CITY OR TOWN OF DEATH Madonna		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4116 Harford Creamery Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE Maryland					13b. COUNTY Harford		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Nick Markline Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Fieseler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-38-0049		17. INFORMANT ADDRESS Ben H. Markline same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Cerebrovascular Disease (c) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 med. may years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None										
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) None						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the physician) attended the deceased from 5/12 , 19 82 , to 6/14 , 19 83 , that (I) (the) last saw the deceased above , (I) (the) view the body after death. and that in (my) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE James F. White, Jr. MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/15/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. WHITE, JR.				22e. ADDRESS Box 97, Jarrettsville, Md. 21084						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/18/1983		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Madonna, Harford, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.				25a. DATE REC'D. BY REGISTRAR JUN 22 1983 25b. REGISTRAR'S SIGNATURE John J. Carver						

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Earl Howard Montgomery			June 7, 1983			M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 5, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2803 Charles St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Mechanic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2803 Charles St 21047	
14. FATHER'S NAME FIRST MIDDLE LAST William Montgomery				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Yeary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 370-26-6865		17. INFORMANT Mrs Ann Montgomery			ADDRESS Same As 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>1919</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>GLIOBLASTOMA MULTIFORME</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>APRIL 1983</u> <u>THRU</u> <u>JUNE 7/83</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION <u>APRIL/82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN TUMOR</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 22</u> , 19 <u>83</u> , to <u>JUN 27</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>JUNE 27</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Benedicto S Garin M.D.</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/7/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benedicto S Garin M.D.				22e. ADDRESS 2406 Baldwin Mill Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/10/83		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE RECD. BY REGISTRAR JUN 8 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

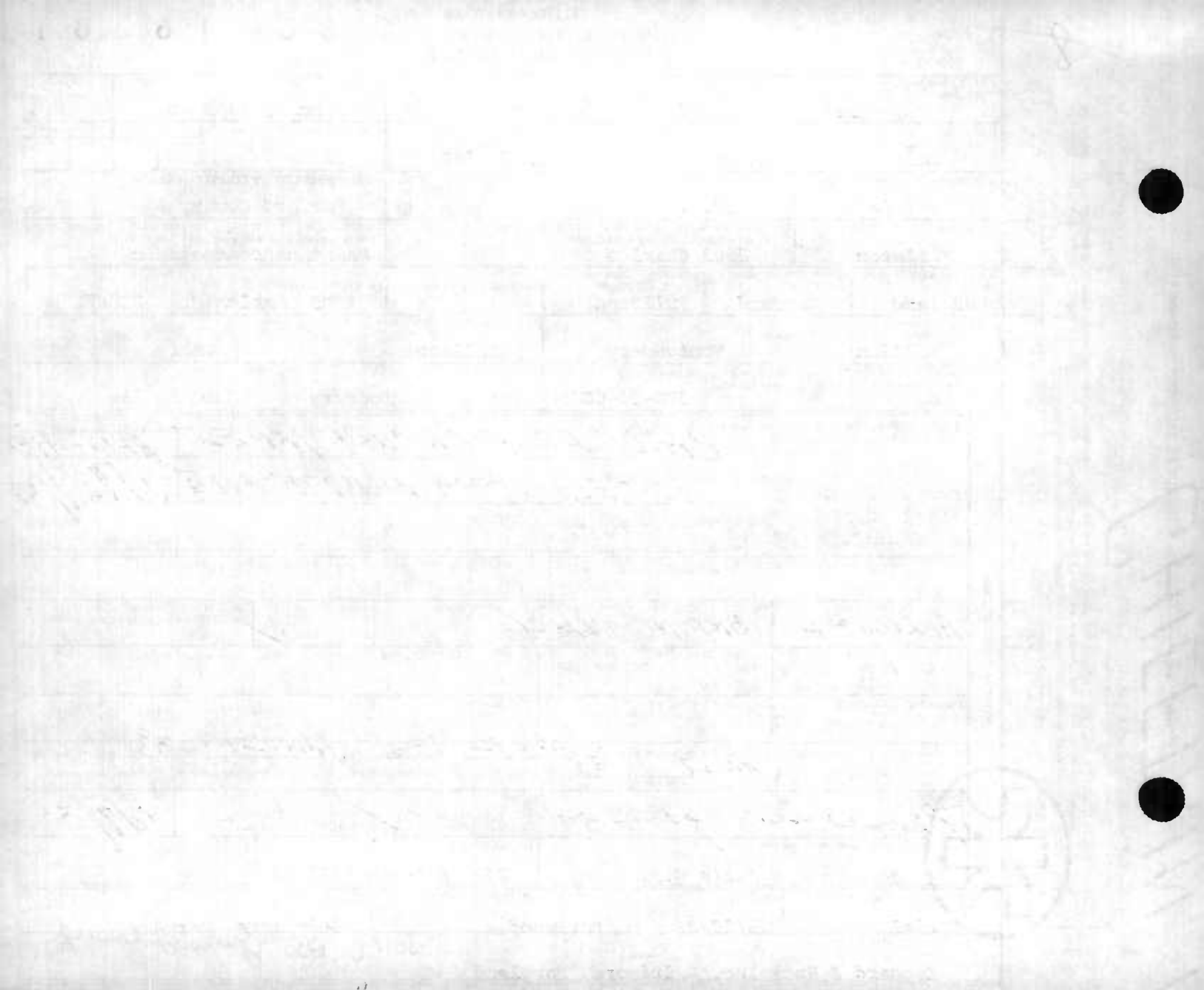
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Macie Annabelle Mull</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>06 06 83</i> 2b. HOUR <i>8:30</i> PM				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 21, 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.			
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston Gen. Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>--</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Edgewood</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>21040 1143 Chipper Drive</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clark -- McCoy</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Gertrude -- McCoy</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-12-4709</i>		17. INFORMANT ADDRESS <i>Kenneth P. Mull, Rt. 1, Box 118A New Ringgold, Pa. 17960</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>VENTRICULAR Fib</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>E.H.D.</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>6/6 85</i>					
22. I certify that (I) (this hospital) attended the deceased from <i>6/6 19 85</i> , 19 <i>85</i> , to <i>6/6 19 85</i> , that (I) (we) last saw the deceased alive on <i>6/6 19 85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Joseph Parkhurst</i> DEGREE					22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
22e. ADDRESS					22f. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>June 10, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens, Bel Air</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Harford Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md. 21009</i>					25a. DATE REC'D. BY REGISTRAR <i>JUN 8 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Casper</i>		

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1989 JUN 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 6 3 8 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DEWEY A. MULLINS				2a. DATE OF DEATH MONTH DAY YEAR 6-30-83		2b. HOUR 2 43 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 15, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automobile	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Street		13e. STREET ADDRESS 3304 Conowingo Road 21154	
14. FATHER'S NAME FIRST MIDDLE LAST Scott Mullins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chury Underwood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW2 235-26-6305		17. INFORMANT ADDRESS Margaret L. Mullins, 3304 Conowingo Road, Street, MD 21154			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial infarction							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Rheumatoid arthritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/2/55 , 19____, to 6/30/83 , 19____, that (I) (we) lost saw the deceased alive on 8/26/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Barthel M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Barthel M.D.		22e. ADDRESS 2501 Rocks Rd., Forest Hill, Md. 21050					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 2, 1983		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gdns		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS John H. Harkins, 600 Main Street, Delta, PA				25a. DATE REC'D. BY REGISTRAR JUL 11 1983			
				25b. REGISTRAR'S SIGNATURE John J. Canine			

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Robert L. Johnson

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2501 Rocks Rd., Towson, Md. 21204

Robert Barfield, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 3 1 6 3 8 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Melvin Eugene Murphy				2b. HOUR 12:50 PM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 9, 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital 21078		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Splicer		12b. KIND OF BUSINESS OR INDUSTRY Utility	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13e. STREET ADDRESS 420 Chestnut St., Aberdeen, MD 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Allen Murphy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Tennent			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-07-4264		17. INFORMANT ADDRESS Mrs. Midred V. Murphy Aberdeen, MD 21001 420 Chestnut St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1509 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/13, 1983, to 6/13, 1983, that (I) (we) last saw the deceased alive on 6/13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) I D. SOMERVILLE				22e. ADDRESS 400 LEWIS ST HAVRE DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 17, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD 21001-3399				25a. DATE REG. BY REGISTRAR JUN 20 1983			
				25b. REGISTRAR'S SIGNATURE [Signature]			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8316385

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
JOSEPH ADRIEN NOËL								6-19-83										12 ⁵⁶ AM	
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
M		W		8-15-31								51		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Massachusetts		USA						HARFORD CO.										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
HARFORD CO.		FALLSTON GENERAL		Retired		US-Army													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Harford		Edgewood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		705 Tupelo Road		21040									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Joseph Arthur Noel		Rosalia Roy																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		Vietnam		013-24-5372		Mrs. Lieselotte Noël, 705 Tupelo Road		Edgewood, Md. 21040											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5860		Pentricular Fibrillation				Acute Myocardial Infarct, probable													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF		End Stage Renal Failure											
								Coronary Atherosclerosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
Andrew Nowakowski MD		MD		6/19/83															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
ANDREW NOWAKOWSKI MD		125 N. MAIN ST		BEL AIR, MARYLAND															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Burial		June 22, 1983		Trinity Lutheran Cem		Joppa		Harford		Md.									
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
		Howard K. McComas III		Abingdon, Md. 21009		JUN 21 1983		John J. Smith											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) George Malcolm ORR Jr.				2a. DATE OF DEATH MONTH DAY YEAR 6-7-83				2b. HOUR 7 ¹⁵ PM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 18 1925		6. AGE (IN YEARS LAST BIRTHDAY) 57		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer Ret.		12b. KIND OF BUSINESS OR INDUSTRY Selfemployed	
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 517 21911	
14. FATHER'S NAME FIRST MIDDLE LAST George M. Orr Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn S. Tenant					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-30-3259		17. INFORMANT ADDRESS Helen E. Orr(Wife) Same address as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Carcinoma, right lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Status-post laryngectomy and neck dissection for carcinoma of larynx (1974)									
19a. DATE OF OPERATION 01/11/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma, right lung				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/28, 19 81, to 06/07, 19 83, that (1) (we) last saw the deceased alive on 05/12, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.									
22b. SIGNATURE John R. Hankins John R. Hankins, M.D.				DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Hankins, M.D.				22e. ADDRESS 22 South Greene St., Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-11-1983		23c. NAME OF CEMETERY OR CREMATORY ton Darling Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.			
24. FUNERAL DIRECTOR (NAME) Richard L. Goodie Rising Sun, Md.				25a. DATE REC'D. BY REGISTRAR JUN 20 1983					
				REGISTRAR'S SIGNATURE John J. Carver					

BP _____

541

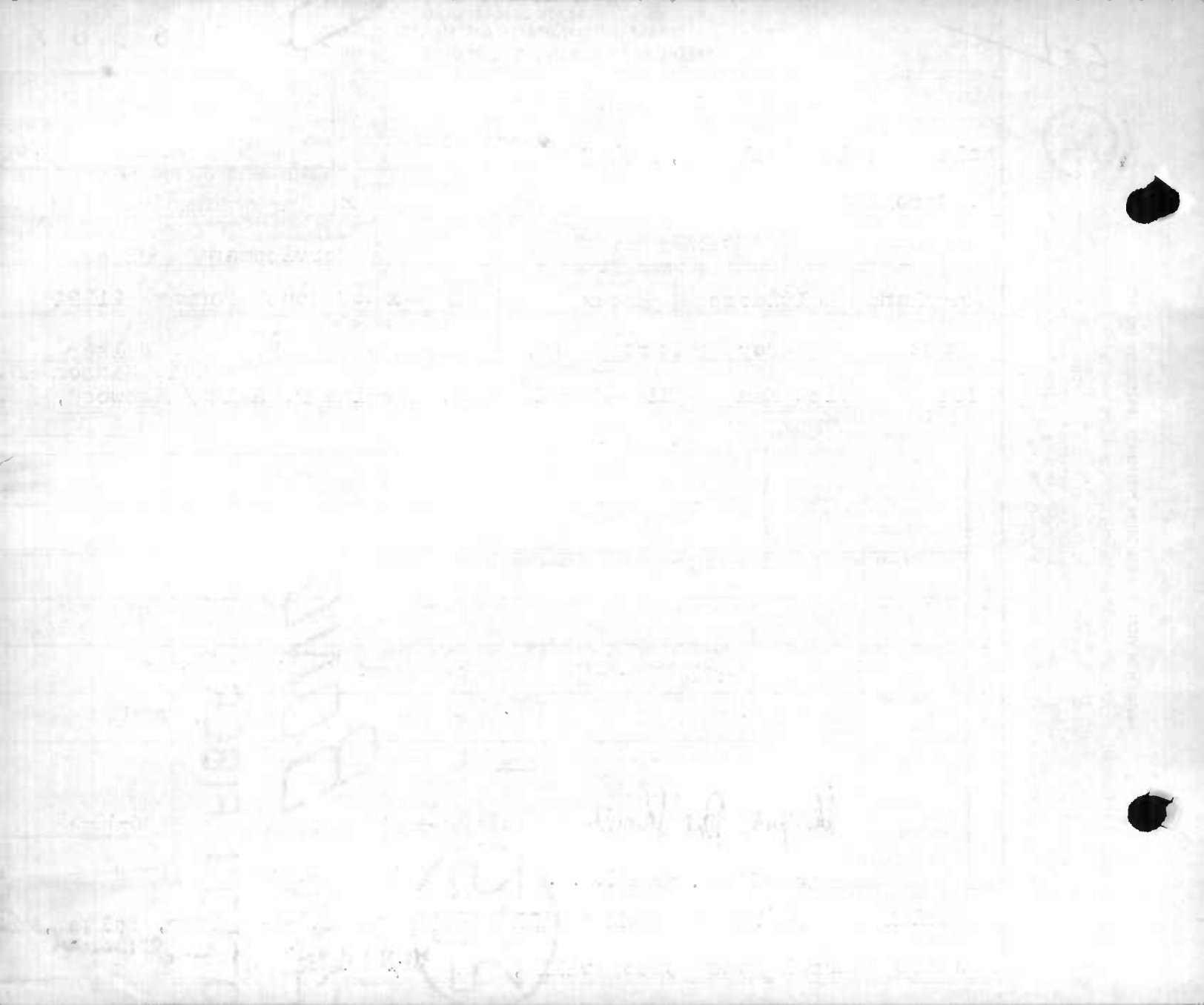
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 1 6 3 8 7	
1. DECEASED NAME (TYPE OR PRINT) BOYD Cameron PARKER						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6-5-83		2b. HOUR M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 25, 1944	6. AGE (IN YEARS) (LAST BIRTHDAY) 38 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 6-9-83		2d. HOUR 3:15P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD					
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Winters Run				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Serviceman		12b. KIND OF BUSINESS OR INDUSTRY US Army			
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 6B South Fenway 21221					
14. FATHER'S NAME FIRST MIDDLE LAST Wyatt Leroy Parker Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcine P. Walker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Viet Nam		16b. SOCIAL SECURITY NO. 218-42-3908		17. INFORMANT ADDRESS 2416 Hanson Rd. Mrs. Marcine P. Smith/Edgewood, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ?? 6-7-83 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found floating in water						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in water		21f. LOCATION STREET CITY STATE Winters Run Edgewood, Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Koroll</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 6-10-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/83		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Grdn.			23d. LOCATION CITY OR TOWN COUNTY STATE Middle River, Balto. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, Md.					25a. DATE REC'D. BY REGISTRAR JUN 14 1983 REGISTRAR'S SIGNATURE <i>John J. Corbett</i>						

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		Harold M. PATRICK				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)		Harold Patrick				2a. DATE OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		2/25/22		61		11:10 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Harford MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston Gen Hosp.				Pipefitter			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Wicomico		Bivalve		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Bx # 47 Texas Rd. 21814	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
George Patrick					Mary Goodman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes					WW 2		Betty Patrick Bx # 47 Bivalve, Md. 21814		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									
4100 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Infarction</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>F.H.D.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		21g. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/23/83</u> to <u>6/26/83</u> , that (I) (we) lost saw the deceased alive on <u>6/23/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>J. Reinhardt for Dr. Vasser</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
J. Reinhardt for Dean Vasser						% Fallston General Hosp. Fallston, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SIC #)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			6/30/83		Chester Cemetery		Chestertown, Md. 21620		
24. FUNERAL DIRECTOR NAME						25. DATE RECEIVED BY REGISTRAR		26. REGISTRAR'S SIGNATURE	
<u>H. Wells Wells</u>						JUN 29 1983		<u>John J. Smith</u>	

RECEIVED
JULY 11 1950
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

FROM: Mr. [Name], [Address], [City], [State]

SUBJECT: [Subject]

[Main body of the letter containing several paragraphs of text, mostly illegible due to fading and bleed-through.]

Very truly yours,
[Signature]

Enclosure

100-100000-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN Marie Phillips			2a. DATE OF DEATH MONTH DAY YEAR 6/15/83		2b. HOUR 6:40 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 29 16		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER				
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Fallston		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 713 Country Village Drive - Apt. 2B				
14. FATHER'S NAME FIRST MIDDLE LAST William James Goslin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Sweeney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 161-07-4894		17. INFORMANT (Husband) 879-2581 ADDRESS Mrs. LEE R. Phillips 713 Country Village Drive - Apt. 2B Fallston, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Central Nervous System Metastases DUE TO, OR AS A CONSEQUENCE OF (c) Breast Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 1749					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Simultaneous 1 month 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from May 1978 to June 1983 , that (I) (we) lost saw the deceased alive on May 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE John R. Wingard				22c. DATE SIGNED 6/15/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Wingard				22e. ADDRESS 600 N. Wolfe Street, Baltimore, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE JUNE 18, 1983		23c. NAME OF CEMETERY OR CREMATORY Highview Memorial Gardens		
23d. LOCATION CITY OR TOWN COUNTY STATE Fallston, Harford Co., Maryland 21047						
24. FUNERAL DIRECTOR Joseph William Foster		24b. ADDRESS W. Broadway & Williams St., Baltimore, Maryland 21014		25a. DATE REC'D. BY REGISTRAR JUN 17 1983		
25b. REGISTRAR'S SIGNATURE John J. Connel						

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					8 3 1 6 3 9 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JETTIE P PLUMMER					2a. DATE OF DEATH MONTH DAY YEAR 6 19 83			2b. HOUR 11:00 P M	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME 21078				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21001 3416 Walnut Road Aberdeen, MD	
14. FATHER'S NAME FIRST MIDDLE LAST Wiley Franklin Parks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Wright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 213-52-7873		17. INFORMANT ADDRESS Rita Holcomb 21001 3416 Walnut Rd., Aberdeen, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old Age 3312 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile atrophy of brain: ASCVD DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION 6-3-83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCVD			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-3-83 to 6-19-83 , that (I) (we) last saw the deceased alive on 6-3-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE Peter P. Rodman M.D.			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-22-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter P. Rodman M.D.			22e. ADDRESS 3548 Churchville Rd. Aberdeen, Md. 21001						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 22 June 1983		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gdns. Bel Air Harford, MD		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Farring Funeral Home, P.A., Aberdeen, MD, 21001-3399			ADDRESS 21001-3399		25a. DATE REC'D. BY REGISTRAR JUN 27 1983		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO. 83 16391					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY GLADYS REXROAD					2a. DATE OF DEATH MONTH DAY YEAR 6/21/83			2b. HOUR MIN 7:10 A M		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 8 1907		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 75 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARTFORD MD.				
10. CITY OR TOWN OF DEATH HARTFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARTFORD MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOSPITAL-NURSES		12b. KIND OF BUSINESS OR INDUSTRY AIDE		
13a. STATE MARYLAND					13b. COUNTY ALLEGANY		13c. CITY OR TOWN FLINTSTONE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES WILLIAM TURNER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA VIRGINIA KEPLINGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 212-24-0241		17. INFORMANT ADDRESS CHARLES REXROAD ALEXANDRIA, VIRGINIA 22308 7919 spotswood DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Intractable CHF. DUE TO, OR AS A CONSEQUENCE OF ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO, OR AS A CONSEQUENCE OF pneumonia - pleural effusion (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-20-83 to 6-21-83, that (I) (we) lost saw the deceased alive on 6-20-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Brian T. Yeon M.D.					22c. DATE SIGNED JUNE 21 1983			22d. DEGREE M.D.		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN T. YEON					22f. ADDRESS HARTFORD MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 24 1983		23c. NAME OF CEMETERY OR CREMATORY GLENDALE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FLINTSTONE ALLEGANY MD.			
24. FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.					25. DATE REC'D. BY REGISTRAR JUN 28 1983					

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Brian T. Year

Have De Grace Maryland

June 21 1938

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 16392	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) MARtha CHRISTINA Rhoads										2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR JUNE 14, 1983	
2b. HOUR 11A. M										2d. HOUR 11A. M	
3. SEX FEMALE										4. RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR August 28, 1897										6. AGE (IN YEARS) LAST BIRTHDAY 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GOWAN Michigan										7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
10. CITY OR TOWN OF DEATH Bel Air										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1328 Prospect Mill Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland										13b. COUNTY Harford Co.	
13c. CITY OR TOWN Bel Air										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 1328 Prospect Mill Road										13f. STREET ADDRESS 21014	
14. FATHER'S NAME FIRST MIDDLE LAST Neils Petersen										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TENA Christiansen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 212-74-5223	
17. INFORMANT (NAME) David J. Rhoads										17. ADDRESS 1202 Tuckahoe Lane Adelphi, Maryland 20783	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) COTONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E. Renjel										TITLE (SPECIFY) Deputy	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.										DATE SIGNED JUNE 14, 1983	
ADDRESS 464 Alliance St., Havre de Grace, Md. 21078											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE June 17, 1983	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens										23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster Joseph William Foster										25a. DATE REC'D. BY REGISTRAR JUN 17 1983	
ADDRESS W. Brandon & Williams St. Bel Air, Maryland 21014										25b. REGISTRAR'S SIGNATURE John J. Canine	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 9 3

1. FOR
STATE
REGISTRAR

REG. NO.

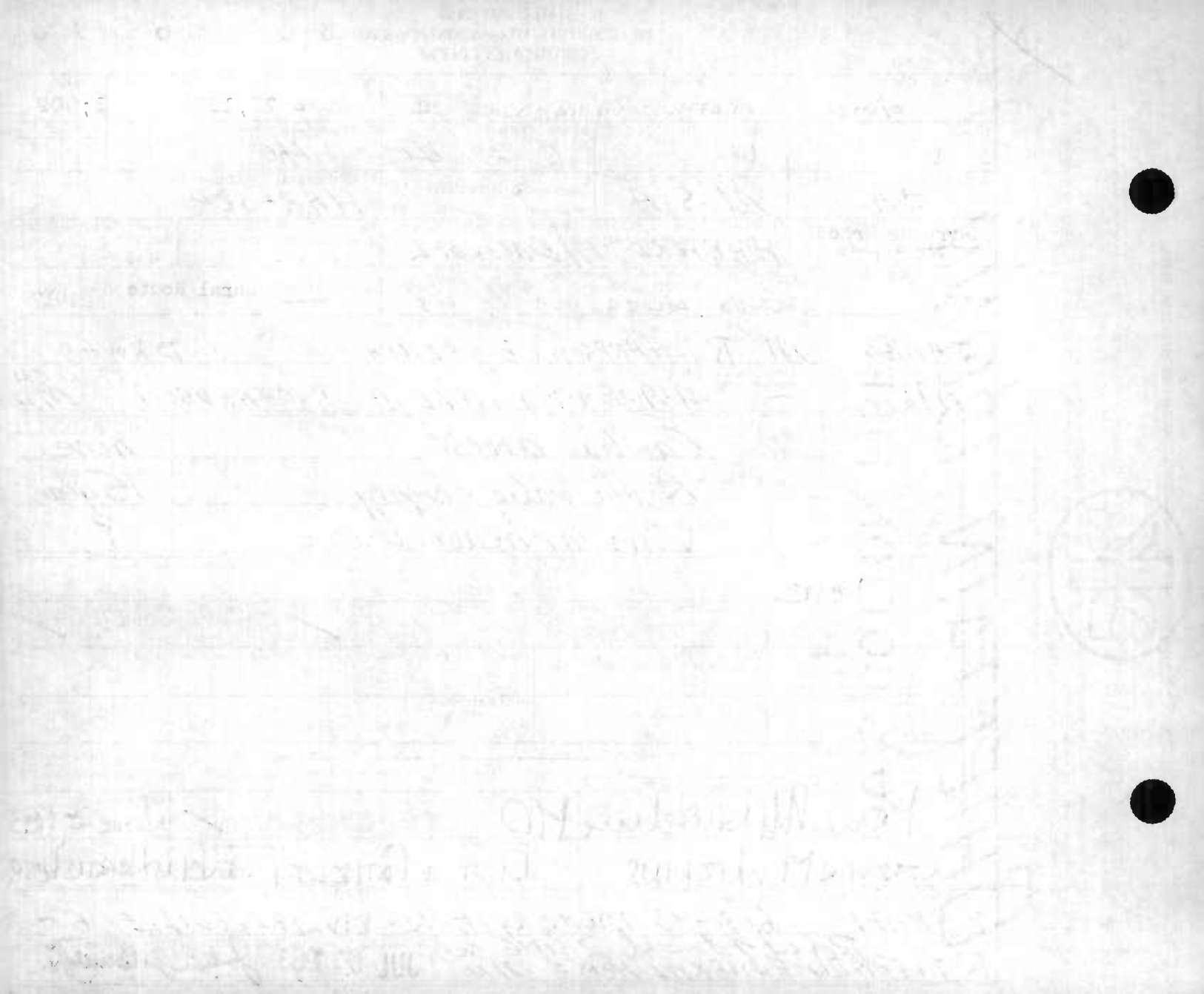
1. DECEASED NAME (TYPE OR PRINT) JAMES MILTON RICHARDSON III			2a. DATE OF DEATH MONTH DAY YEAR JUNE 27, 1983		2b. HOUR 3:00P M
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6 30 41	6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH Harre de Grace COLORA MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HARFORD, GIVE STREET ADDRESS) HARFORD MEMORIAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher		12b. KIND OF BUSINESS OR INDUSTRY school
13a. STATE MD			13b. COUNTY HARFORD	13c. CITY OR TOWN COLORA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JAMES M. RICHARDSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUGENIA BROOKS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 459-68-6954	17. INFORMANT ADDRESS NEEL R. RICHARDSON COLORA MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4241 DUE TO, OR AS A CONSEQUENCE OF (b) Aortic valve surgery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Valvular heart disease DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none 15 years ?					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE GROVER M HUTCHINS MD				22c. DATE SIGNED JUNE 28 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GROVER M HUTCHINS				22e. ADDRESS DEPT OF PATHOLOGY, THE BALTIMORE HOSP	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-30-83	23c. NAME OF CEMETERY OR CREMATORY MEMORY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE MILLEDGEVILLE GA
24. FUNERAL DIRECTOR NAME R.T. FORD FUNERAL HOME MD		24a. DATE REC'D. BY REGISTRAR JUL 6 - 1983		24b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 9 4

1. DECEASED NAME (TYPE OR PRINT) Sophia Schmidt		2a. DATE OF DEATH MONTH DAY YEAR 6 03 83		2b. HOUR 3²⁹ P^M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01-27-1897	
6. BIRTHPLACE (STATE OR COUNTRY) Balto. Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
11. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN HOSPITAL		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland 12b. COUNTY Harford 12c. CITY OR TOWN Forest Hill	
13. FATHER'S NAME FIRST Joseph MIDDLE Koenigs LAST mark		14. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE unknown LAST 21206		15. ADDRESS Jerome J. Schmidt - 5007 Lasalle Ave.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-22-3910		17. INFORMANT Jerome J. Schmidt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA. PULMONARY STASIS. SEPTICEMIA.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a PNEUMONIA. PULMONARY STASIS. SEPTICEMIA.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 3:30 PM , 19 83 , to 3:00 PM , 19 83 , that (I) (we) (us) saw the deceased alive on JUNE 3 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. J. Sweatman		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JUNE 3 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. SWEATMAN M.D.		22e. ADDRESS FALLSTON GENERAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/6/83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. Baltimore	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME Baltimore, Md. 21213 Schimunek Funeral Home 3331 Brehms Ln.			
25a. DATE REC'D. BY REGISTRAR JUN 7 1983		25b. REGISTRAR'S SIGNATURE John J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar's office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 3 9 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank Ralph Schofield			2a. DATE OF DEATH MONTH DAY YEAR JUNE 16 1983		2b. HOUR 7 ⁴⁰ PM		
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 22 1911		6. AGE (IN YEARS LAST BIRTHDAY) XX 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.		12b. KIND OF BUSINESS OR INDUSTRY Ret.	
13a. STATE Md.		13b. CITY OR TOWN Rising Sun		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 21911 1030 New Bridge Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Schofield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marbel Bullette				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 2nd W.W. 218-03-3259		17. INFORMANT ADDRESS Mrs. Pearl Schofield (Wife) Same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) <u>Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-12</u> , 19 <u>83</u> , to <u>6-16</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>6-16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John D. Yun</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN		22e. ADDRESS Havre de Grace, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-20-1983		23c. NAME OF CEMETERY OR CREMATORY Oxford Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Oxford Chester Pa.	
24. FUNERAL HOME Rising Sun, Md.		25a. DATE REC'D. BY REGISTRAR JUN 22 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

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1891
[Faint, mostly illegible text, possibly a ledger or record book with multiple columns and rows of entries.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 6 3 9 6	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
JOSEPH FORBES SHEETS			6-4-83			12:30A					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Male			White			9-7-10			72 YRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
West Va.			U.S.A.						Harford MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Fallston			Fallston General Hosp.			Ret. Carpenter			construc.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Harford			Bel Air			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Ollie XXXX --			Sibbie XXXX Elizabeth Miller			XXXXXXX			232-24-8052		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Bel Air, Md. 21014			Respiratory Failure.						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			(b) Chronic Obstructive Pulmonary Dis.						20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure, Ca of prostate.											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 5-5-83, 19, to 6-4-83, 19, that (we) last saw the deceased alive on 6-4-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME			22e. ADDRESS			22f. DEGREE			22g. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
Jorge H. Orozquez-Smith M.D.			Fallston, Md.						6-4-83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			June 6, 1983			Baptist View Cemetery			Forest Hill Harford Md.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Howard K. McComas III, Abingdon, Md. 21009			JUN 6 1983			John J. Canine					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 1 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ALBERT John Smith					2a. DATE OF DEATH MONTH DAY YEAR 6 12 1983			2b. HOUR 10 56 AM	
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 17 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital 21047				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY Industrial	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STREET ADDRESS				
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS MD 21028 3413 McCommons Rd., Churchville	
14. FATHER'S NAME FIRST MIDDLE LAST Albert J. Schmitt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Sameth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II					16b. SOCIAL SECURITY NO. 215-03-3667		17. INFORMANT ADDRESS Dorothy J. Smith 3413 McCommons Rd., 21028 Churchville, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 9 YEARS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a obstructive lung disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-22-83 to 6-27-83 , that (I) (we) last saw the deceased alive on 3-30-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. J. Plunkett, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-28-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry J. Plunkett, MD					22e. ADDRESS 617 W. Bel Air Ave. Aberdeen, MD 21001				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford MD		
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399					25a. DATE REC'D. BY REGISTRAR JUL 5 1983		25b. REGISTRAR'S SIGNATURE John J. Carver		

BP

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gurney (Guerney)		FIRST G.		MIDDLE 		LAST Smith		2a. DATE OF DEATH MONTH DAY YEAR June 14 1983				2b. HOUR 3:30 P.M.											
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 22 97				6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.				IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.															
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 				12b. KIND OF BUSINESS OR INDUSTRY 											
13a. STATE MO		13b. COUNTY Harford		13c. CITY OR TOWN Whitehall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Norris Phil Rd. 21161															
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Nelson																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-22-2374		17. INFORMANT ADDRESS Mary Evans 4102 Evans Chapel Rd.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) 														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 																							
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 															
22a. I certify that (I) (this hospital) attended the deceased from 6-12 , 19 83 , to 6-14 , 19 83 , that (I) (we) lost saw the deceased alive on 6-14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																							
22b. SIGNATURE G. Hirsch														DEGREE 		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Günther Hirsch														22e. ADDRESS 131 S. Union Ave. Havre de Grace, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/18/83		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air MO													
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March E/H 1101 E. North Ave.																25a. DATE REC'D. BY REGISTRAR JUN 16 1983		25b. REGISTRAR'S SIGNATURE John J. Connel					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

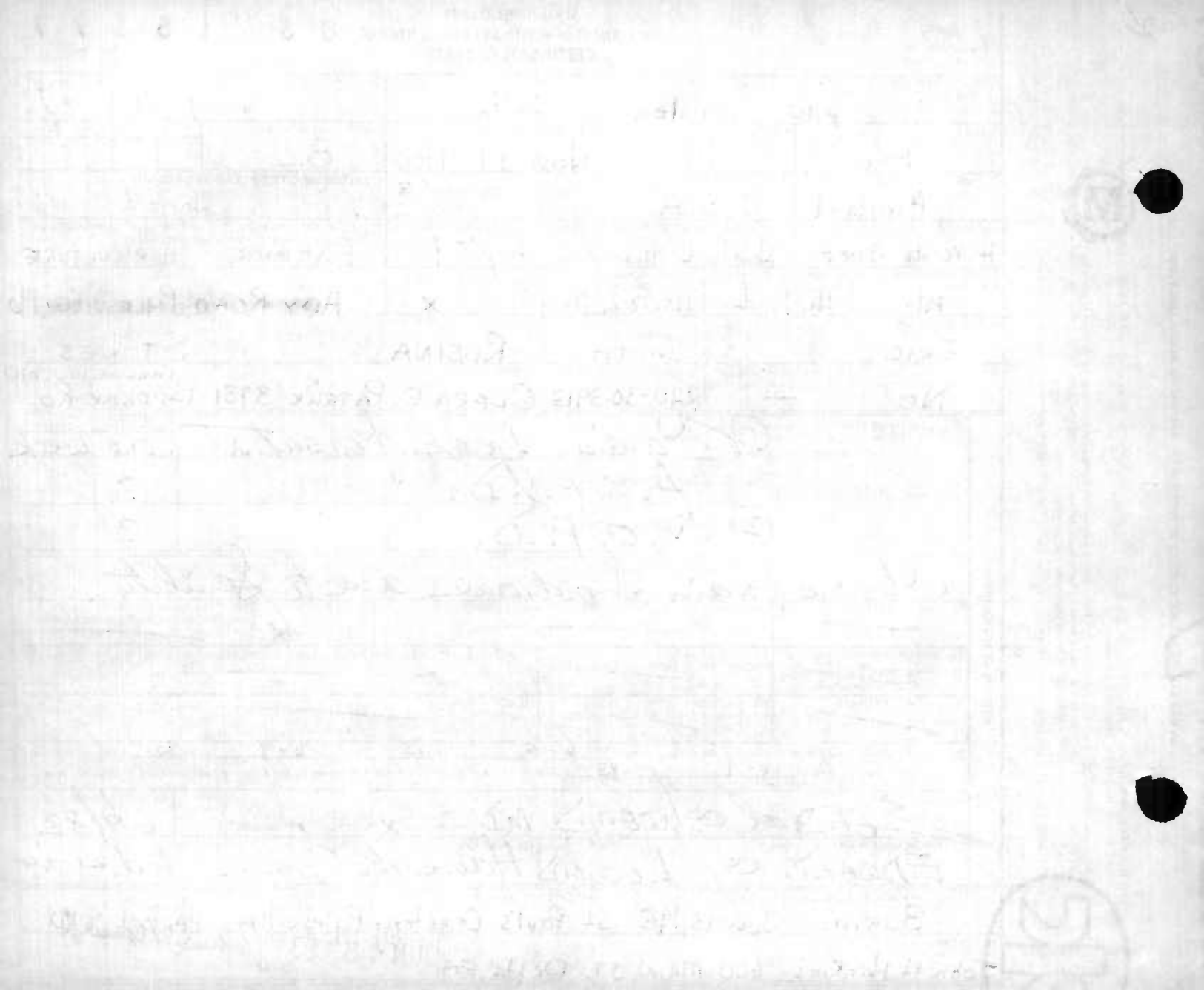
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death.

TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: This certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

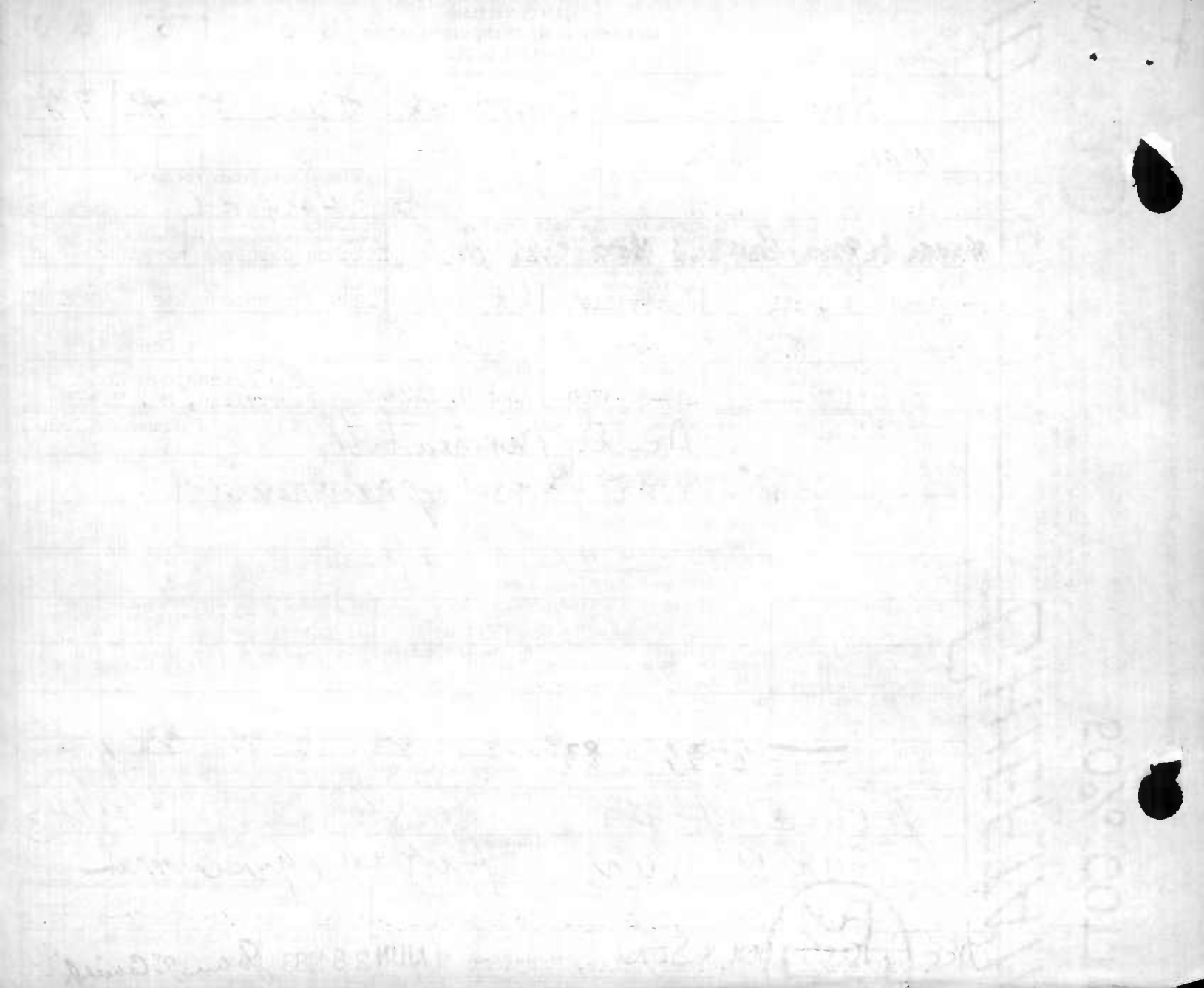
8 3 1 6 4 0 0

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Roy Franklin Smith Sr.		JUNE 21 1983		9 18 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	43	IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.		Harford MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Harford	Harford Memorial Hosp.		Kitchen Helper		Maryland House
13a. STATE		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS
Maryland	Cecil	Perryville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1200 Frenchtown Road 21903
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Warren H. Smith		Ethel Ganoe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		219-34-4700		Anna M. Likens	
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5770 IMMEDIATE CAUSE (a) Acute pancreatitis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Acute Bronchopneumonia			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-18-83 to 6-21-83, that (I) (we) lost saw the deceased alive on 6-21-83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
John D. Yun		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
John D. Yun		Hainedegre, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		June 23, 1983		Bel Air Memorial Gardens	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
		Bel Air		Harford Md.	
23g. FUNERAL DIRECTOR		23h. DATE REC'D. BY REGISTRAR		23i. REGISTRAR'S SIGNATURE	
Lee A. Patterson & Son, Perryville, Maryland		JUN 28 1983		John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 16401			
1. DECEASED NAME (TYPE OR PRINT) Clyde David Therrien				2a. DATE OF DEATH MONTH DAY YEAR June 17, 1983				2b. HOUR 3:24 A.M.			
3 SEX MALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 1, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LAURENCE MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10 CITY OR TOWN OF DEATH Fallston (21047)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Military		12b. KIND OF BUSINESS OR INDUSTRY U.S.M.C. Marine Corps			
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air (21014)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 205 Idlewild Street - Apt. 2C			
14 FATHER'S NAME FIRST MIDDLE LAST David Therrien				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Shattuck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1927-1957		17 INFORMANT (NAME) Mrs. Dora G. Therrien		17a. ADDRESS 205 Idlewild St. - Apt. 2C Bel Air, Maryland 21014					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/11/83 to 6/14/83 , that (I) (we) lost saw the deceased alive on 6/14/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John D. Yun, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED June 17, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun, M.D.				22e. ADDRESS 319 S. Union Ave., HAVRE DE GRACE, Md. 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE JUNE 20, 1983		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR, Harford Co., Maryland 21014					
24 FUNERAL DIRECTOR Joseph William Foster W. Brandy & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR JUN 21 1983		25b. REGISTRAR'S SIGNATURE John S. Gresham							

BP



Centre Hypocentral Information

6/14 83 6/14 83 6/14 83

John Doe

John Doe
1000 Main Street
New York, NY 10001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 4 0 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLYDE E HENRY THOMPSON		2a. DATE OF DEATH MONTH DAY YEAR 6 9 1983		2b. HOUR 4:37 M
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Oct. 28 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ballistic Research	12b. KIND OF BUSINESS OR INDUSTRY APG
13a. STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN Harford	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 714 Alliance ST. 21078
14. FATHER'S NAME FIRST MIDDLE LAST James --- Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah --- Harris		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ----		16b. SOCIAL SECURITY NO. 215-09-5101		
		17. INFORMANT ADDRESS Helen C. Thompson Harford, Md. 21078		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

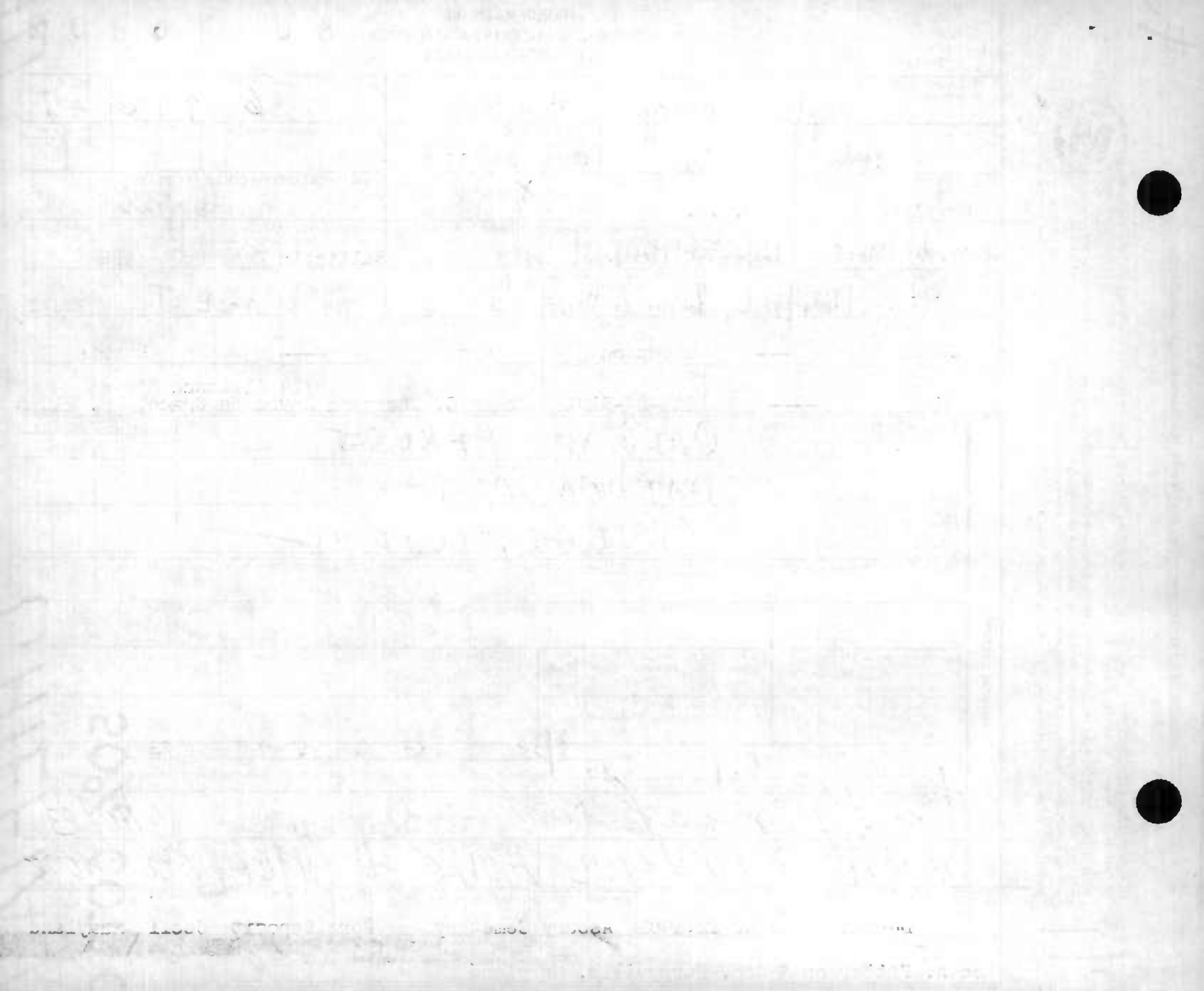
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/25, 1983, to 6-9, 1983, that (I) (we) last saw the deceased alive on 6-9, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Dante W. Monakil	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/10/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE W. MONAKIL		22e. ADDRESS Harford, Md 21078	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 12, 1983	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Lee A. Patterson & Son, Perryville, Maryland		25a. DATE RECD BY REGISTRAR JUN 15 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 16403

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HELEN ELIZABETH TOWERS			2a. DATE OF DEATH MONTH DAY YEAR June 20, 1983		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 4, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Edgewood	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1907 Hawthorne Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Edgewood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Frederick Keetz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose M. Haag		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 373-72-6754		17. INFORMANT ADDRESS Edgewood, Md. 21040 Thomas D. Towers, 1907 Hawthorne Road	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

BRONCHOPNEUMONIA & RENAL FAILURE

0389

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) SEPTICEMIA (ABO INJURY) - SEVERITY

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 19 78, to present 19, that (I) (we) lost saw the deceased alive on June 3 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Rafiq K. Patel	DEGREE	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafiq K. Patel, M.D.	22e. ADDRESS 2013 Pulaski Highway, Edgewood, Md. 21040	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE June 20, 1983	23c. NAME OF CEMETERY OR CREMATORY Reitz-Herzberg F.H.	23d. LOCATION CITY OR TOWN COUNTY STATE Saginaw Saginaw Michigan
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JUN 22 1983	25b. REGISTRAR'S SIGNATURE John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 4 0 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Rose Burman Underwood</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 28 1983</i>			2b. HOUR <i>3:30 A.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 12 '24</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>59 yrs</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i> MD.			
10. CITY OR TOWN OF DEATH <i>Hartford</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem. Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Darlington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>4043 Conowingo Rd. 21034</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Lewis Wright</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nell Rose Connely</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>126-30-9224</i>		17. INFORMANT ADDRESS <i>Junior W. Underwood 4043 Conowingo Rd. Darlington Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> <i>4149</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HAS COPD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>CAD</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>6-28</i> , 19 <i>83</i> , to <i>6-28</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>6-28</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. T. Lee</i>					DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. T. Lee</i>					22e. ADDRESS <i>Underwood Med. Clinic. Hdq. MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>7/1/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Gardens</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bel Air Harford Md.</i>		
24. FUNERAL DIRECTOR NAME <i>John H. Harkins</i>					ADDRESS <i>600 Main St., Delta Pa., 17314</i>		25a. DATE REC'D. BY REGISTRAR <i>14 JUL 5 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>

BP

3

1. The first of the three items is a letter from the

author to the editor of the journal, dated 1964.

2. The second item is a letter from the editor to the

author, dated 1964, in which the editor expresses his

disapproval of the author's use of the word "theory" in

the title of the article.

3. The third item is a letter from the author to the

editor, dated 1964, in which the author explains his

reason for using the word "theory" in the title.

4. The fourth item is a letter from the editor to the

author, dated 1964, in which the editor expresses his

disapproval of the author's use of the word "theory" in

the title of the article.

5. The fifth item is a letter from the author to the

editor, dated 1964, in which the author explains his

reason for using the word "theory" in the title.

6. The sixth item is a letter from the editor to the

author, dated 1964, in which the editor expresses his

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20X5
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Alfred			MIDDLE Van			LAST Houtin			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 6-10			DAY 1983			YEAR 2A			HOUR M		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 16 10			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 6 10 1983			2d. HOUR 6A			M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.														
10. CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1404 Churchville Rd.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE MD				13b. COUNTY Harford				13c. CITY OR TOWN Bel Air				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS Belair, Md. 21014 1404 Churchville Rd.										
14. FATHER'S NAME FIRST MIDDLE LAST Van Houtin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Van Houtin																						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 199-05-5832				17. INFORMANT Personal Papers				ADDRESS														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4140</u> <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																										
ACTUAL SIGNATURE <u>Luis E. Renjel</u> M.D. Deputy										TITLE (SPECIFY) MEDICAL EXAMINER				DATE SIGNED 6-10-83												
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.										ADDRESS 464 Alliance St. Havre De Grace, MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 6/11/83				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE														
24. FUNERAL DIRECTOR NAME Anatomy Board										ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR JUN 17 1983				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>								



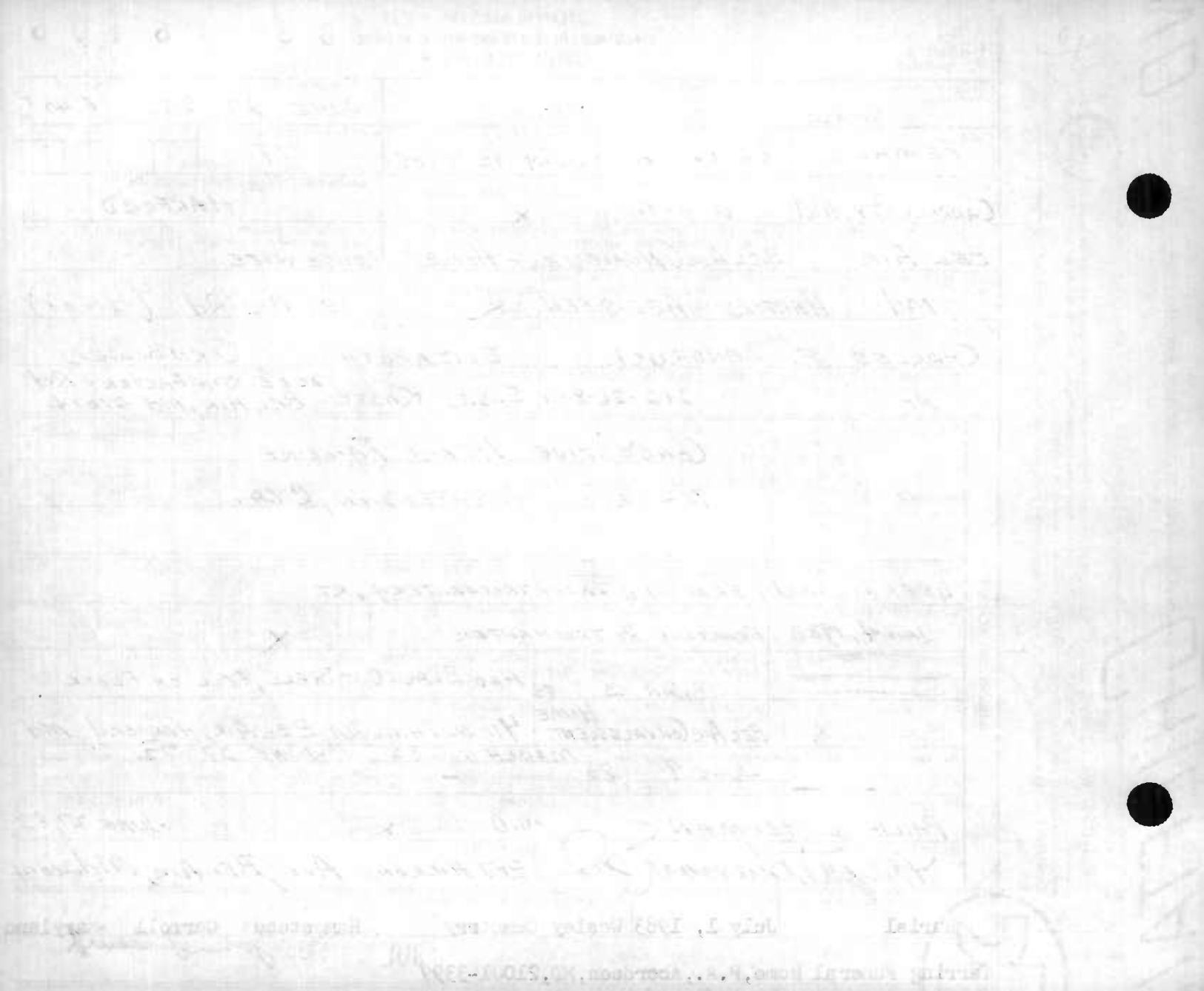
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Regularly be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 1 6 4 0 6				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Grace A. Wagner					2a. DATE OF DEATH MONTH DAY YEAR JUNE 27, 1983			2b. HOUR 6:40 P M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 12 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CARROLL CT, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH BEL AIR		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL AIR CONVALESCENT HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN ABERDEEN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 136 Post Rd. (21001)	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES F. SANDRUCK					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH CORNBOWER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-26-8011		17. INFORMANT ADDRESS 207 E. RING FACTORY Rd BEL AIR, MD 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES, HYPERTENSION, C.V.A. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) DEPRESSION, FRACTURE INTERTROCHANTERIC, RT									
19a. DATE OF OPERATION JAN 4, 1983			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE RT TROCHANTER			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. JAN 3 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) HAD BLACKOUT SPELL, FELL ON FLOOR			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) HOME			21f. LOCATION CITY OR TOWN COUNTY STATE 410 McPHAIL Rd, BEL AIR, HARFORD, MD			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 11, 1982 to JUNE 27, 1983 , that (I) (we) last saw the deceased alive on JUNE 9, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE PHILIP W. HEUMAN					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED JUNE 27, 83	
22d. PHYSICIAN'S NAME (PRINT) Philip W. Heuman					22e. ADDRESS 307 HICKORY AVE., BEL AIR, MD 21014				
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 1, 1983		23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Carroll, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399					25. DATE REC'D. BY REGISTRAR JUL 5 1983				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 3 1 6 4 0 7			
1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sadie Amanda Wilson				2a. DATE OF DEATH MONTH DAY YEAR 6-4-83		2b. HOUR 8¹⁰ AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 1 12 96		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Bel Air (21014)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland				13b. CITY OR TOWN Harford		13c. STREET ADDRESS 803 Cashew Court	
14. FATHER'S NAME FIRST MIDDLE LAST Emory Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Brandenberg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 526-22-9321		17. INFORMANT (NAME) ADDRESS Mrs. Geneva Lee Heaps 1612-B REBECCA COURT FOREST HILL, MARYLAND 21050	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESP. FAILURE 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRO-VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF, MOST (c) ADVANCED ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH @ 24 HRS 6 DAYS 3 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MORE THAN 10 YRS to 4 JUNE 19 83 , that (I) (we) lost saw the deceased alive on 3 JUNE 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. P. Sidwell M.D.				DEGREE M.D.		22c. DATE SIGNED 4 June 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. P. SIDWELL M.D.				22e. ADDRESS 461 FRANKLIN ST BEL AIR, MD 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE JUNE 7, 1983		23c. NAME OF CEMETERY OR CREMATORY CENTRE METH. CH. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford Co, Maryland 21050	
24. FUNERAL DIRECTOR Joseph William Foster Bel Air, Maryland 21014				25a. DATE REC'D. BY REGISTRAR JUN 7 1983			
				25b. REGISTRAR'S SIGNATURE John J. Canfield			

BP

REG. NO.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	June 22, 1983	St. Pius V Cemetery	Cannon Falls	Goodhue	
24. FUNERAL DIRECTOR NAME	John A. Moran, Inc. Funeral Home		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
3000 E. Baltimore St.-Balto., Md.	21224	JUN 20 1983	John J. Conner		

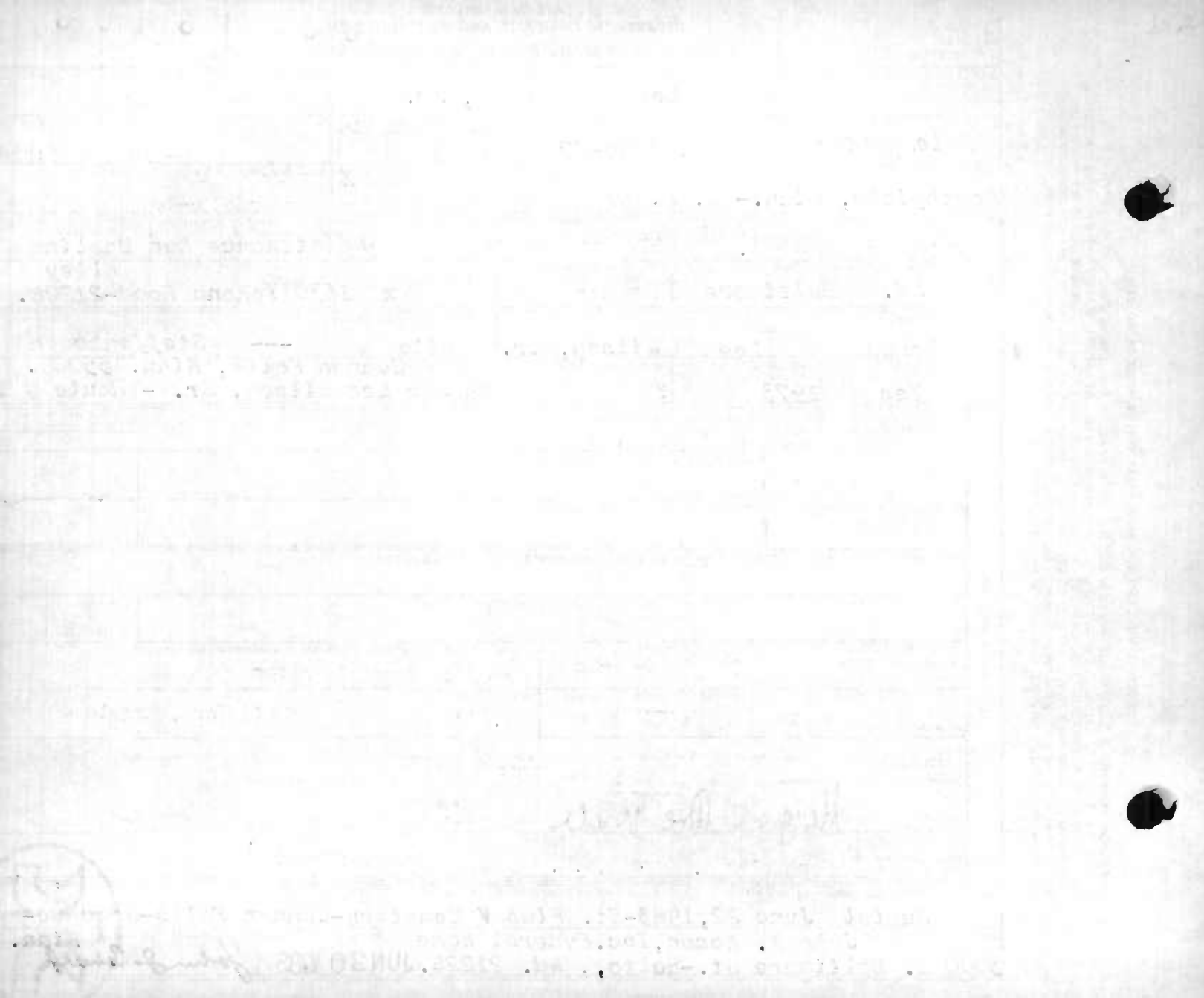
BP_____

DHMH - 17

(VR A15 ME (5))

20M 4/82

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 6 4 0 9

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Lola W. Woodhand</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 29 83</i>			2b. HOUR <i>3:45 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 23, 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Norfolk, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hagerford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Citizens Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
13a. STATE <i>Md.</i>		13b. CITY OR TOWN <i>Cecil</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <i>Box 532 21901</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Williams</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Bright</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-74-2010</i>		17. INFORMANT ADDRESS <i>Virginia W. Cruse Box 532 North East, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>① Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>② Cardiac Decompensation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>A.S. C.V. D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4292</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Senility, old C.V.A., Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. <i>19</i>		21b. TIME OF INJURY HOUR—A.M. MONTH DAY YEAR <i>9/14 1979</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/29/83</i> to <i>6/29/83</i> , that (I) (we) last saw the deceased alive on <i>6/29/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward C. Loo, M.D.</i> DEGREE PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>6/29/83</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>June 30, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gilpin Manor Mem. Pk. Elkton</i>	
24. FUNERAL DIRECTOR NAME <i>SEE FUNERAL HOME</i>		24b. ADDRESS <i>Elkton, Md.</i>		25a. DATE REG'D. BY REGISTRAR <i>JUL 14 1983</i>		25b. REGISTRAR'S SIGNATURE <i>Cecil Smith</i>	

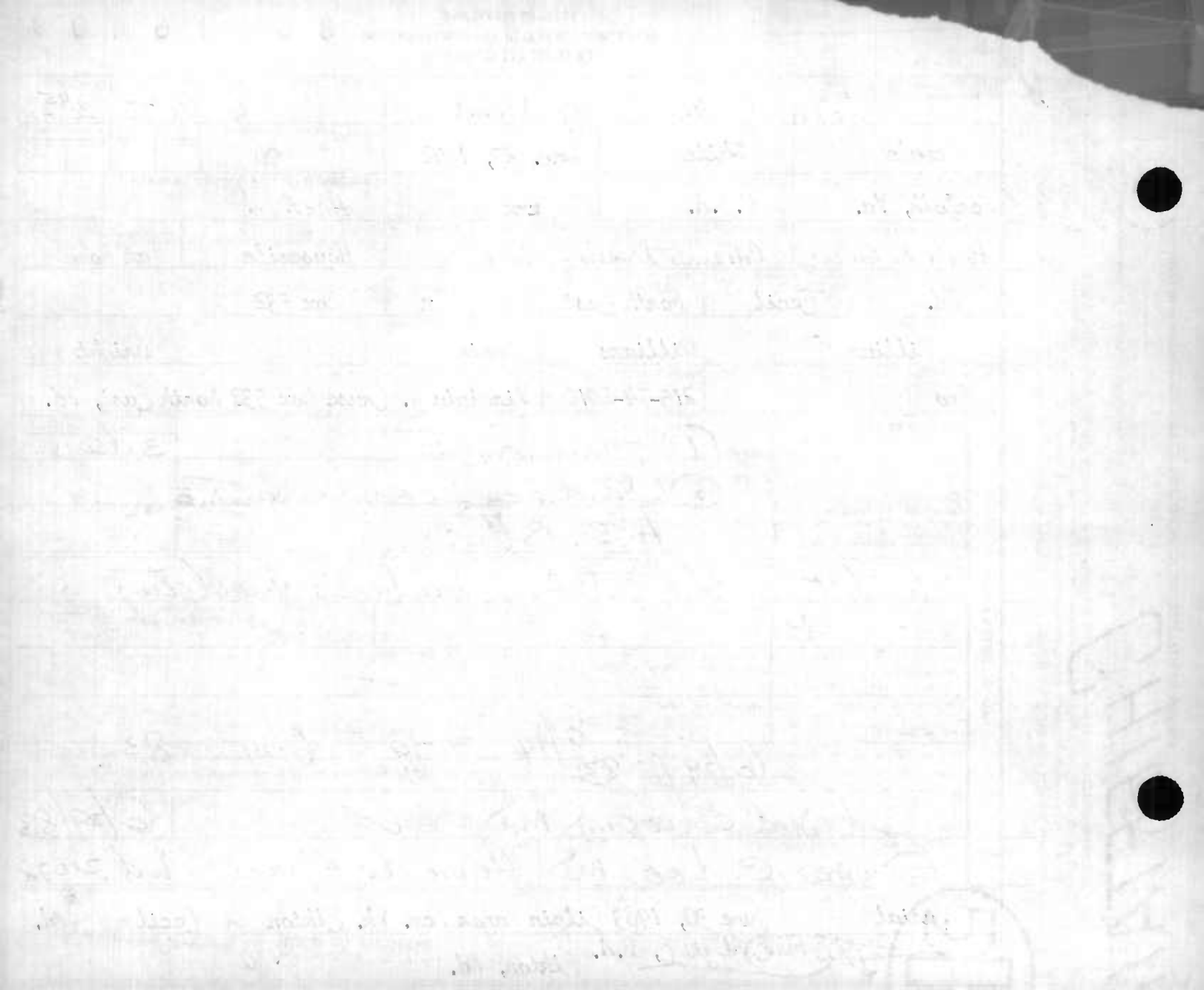
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examination for criminal purpose.

BP



FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 6 4 1 0			
				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) George Thomas Woodward				2a. DATE OF DEATH MONTH DAY YEAR June 14 1983				2b. HOUR 3:30 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 28, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.					
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chem. Engr.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Hartford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1108 Red Pump Road	
14. FATHER'S NAME FIRST MIDDLE LAST Alban Chesterfield Woodward				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 377-07-3851		17. INFORMANT (NAME) ADDRESS (Mrs.) 838-7024 1108 Red Pump Road Mrs. Marguerite M. Woodward Bel Air, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car fire caused 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac shock DUE TO, OR AS A CONSEQUENCE OF (c) Aortic myocardial infarct APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) Atherosclerotic cardiovascular disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-14-83 to 6-14-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased alive on above, (I) (we) (did) (did not) view the body after death.)											
22b. SIGNATURE H. H. H. H. H.				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. H. H. H. H.				22e. ADDRESS H. H. H. H. H.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE JUNE 16, 1983		23c. NAME OF CEMETERY OR CREMATORY Crown & Pettis Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester, West Chester Twp, Penna. 19380			
24. FUNERAL DIRECTOR Joseph William Foster Foster & Sons				24b. ADDRESS 21014				25a. DATE REC'D. BY REGISTRAR JUN 17 1983			
				25b. REGISTRAR'S SIGNATURE John J. Smith							

3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

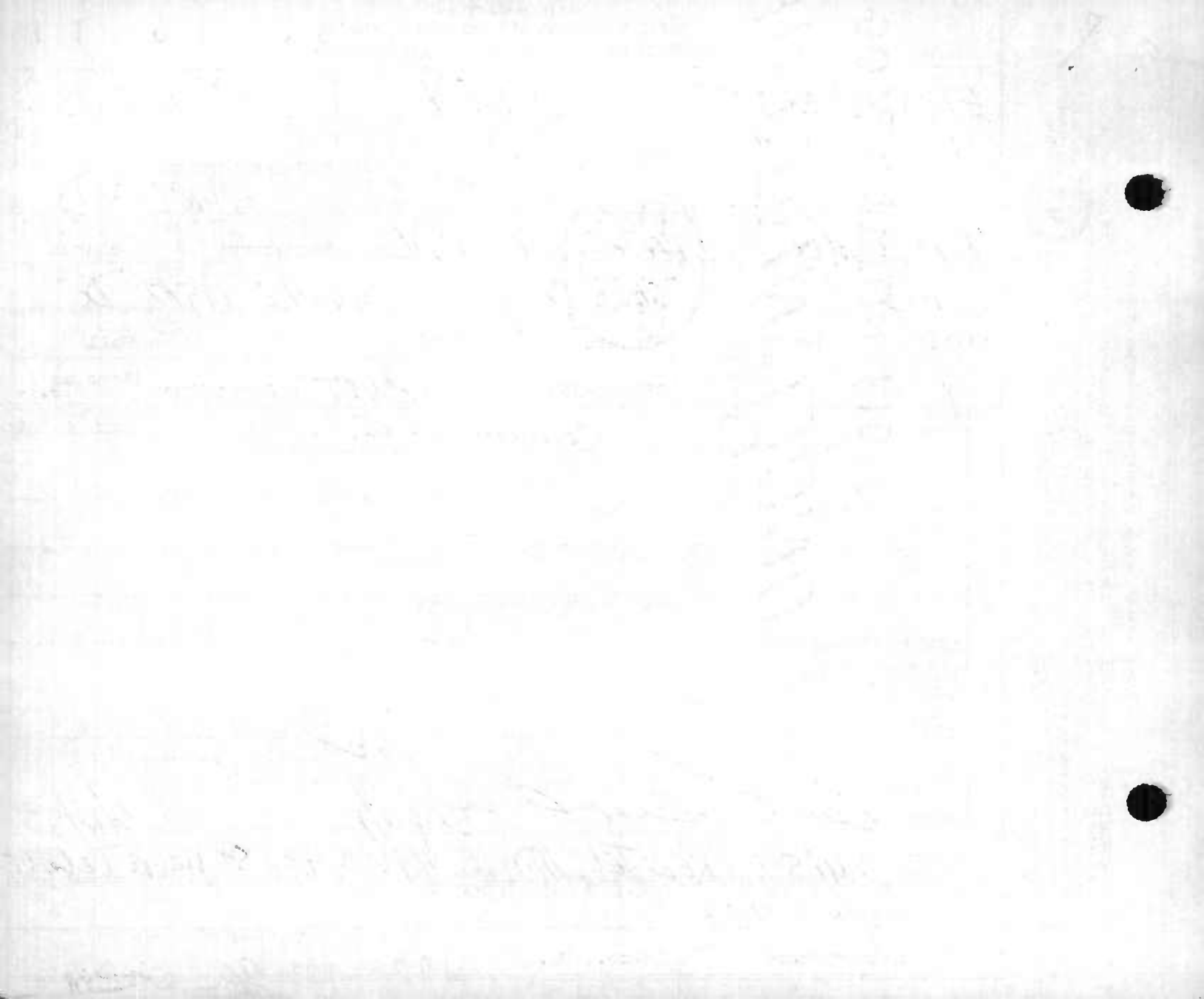
REG NO. 3 16411

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		2c. DATE OF DEATH		2d. DATE OF DEATH		2e. DATE OF DEATH		2f. DATE OF DEATH		2g. DATE OF DEATH		2h. DATE OF DEATH		2i. DATE OF DEATH		2j. DATE OF DEATH		2k. DATE OF DEATH		2l. DATE OF DEATH		2m. DATE OF DEATH		2n. DATE OF DEATH		2o. DATE OF DEATH		2p. DATE OF DEATH		2q. DATE OF DEATH		2r. DATE OF DEATH		2s. DATE OF DEATH		2t. DATE OF DEATH		2u. DATE OF DEATH		2v. DATE OF DEATH		2w. DATE OF DEATH		2x. DATE OF DEATH		2y. DATE OF DEATH		2z. DATE OF DEATH																																																																																					
1. DECEASED NAME (TYPE OR PRINT)		2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS)		6. IF UNDER 1 YR.		7. IF UNDER 24 HRS.		8. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY		14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. STATE		16. COUNTY		17. CITY OR TOWN		18. INSIDE CITY LIMITS?		19. STREET ADDRESS		20. ZIP CODE		21. FATHER'S NAME		22. MOTHER'S MAIDEN NAME		23. WAS DECEASED EVER IN U.S. ARMED FORCES?		24. SOCIAL SECURITY NO.		25. INFORMANT		26. ADDRESS		27. (Same as #13.)		28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		29. PART 1 DEATH WAS CAUSED BY:		30. IMMEDIATE CAUSE (a)		31. DUE TO, OR AS A CONSEQUENCE OF		32. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST		33. (b)		34. DUE TO, OR AS A CONSEQUENCE OF		35. (c)		36. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		37. DATE OF OPERATION		38. CONDITION FOR WHICH OPERATION WAS PERFORMED		39. AUTOPSY?		40. YES		41. NO		42. 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		43. 21b. TIME OF INJURY		44. 21c. HOW INJURY OCCURRED		45. 21d. INJURY OCCURRED WHILE AT WORK		46. 21e. PLACE OF INJURY		47. 21f. LOCATION		48. 22a. I certify that I took charge of the remains described above, held on death resulted from:		49. Natural causes		50. Accident		51. Suicide		52. Homicide		53. Undetermined manner		54. ACTUAL SIGNATURE		55. TITLE (SPECIFY)		56. M.D.		57. MEDICAL EXAMINER		58. DATE SIGNED		59. EXAMINER'S NAME		60. ADDRESS		61. 23a. BURIAL, CREMATION, REMOVAL		62. 23b. DATE		63. 23c. NAME OF CEMETERY OR CREMATORY		64. 23d. LOCATION		65. 24. FUNERAL DIRECTOR		66. NAME		67. ADDRESS		68. 25a. DATE REC'D. BY REGISTRAR		69. 25b. REGISTRAR'S SIGNATURE	

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

John J. Smith



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 16412

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) STELLA MARGARET ZARKO			2a. DATE OF DEATH MONTH DAY YEAR 6 2 83			2b. HOUR 18 6p M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 12 25		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Glass Inspector		12b. KIND OF BUSINESS OR INDUSTRY Glass	
13a. STATE Maryland				13b. CITY OR TOWN Bel Air		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stanley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Zulewski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 193-05-4632		17. INFORMANT Wanda M. Redys		ADDRESS 222 Timber Trail Bel Air, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

4920

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

Cardiac failure, Cachexia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Mar 29, 83 to June 2, 83 , that (II) (we) lost sight of the deceased alive on June 2, 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) sign the body after death.							
22b. SIGNATURE Albert S.C. Sun, m.d.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S.C. Sun, m.d.		22e. ADDRESS 1800 Harford Rd. MD 21047					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-6-83		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Memorial Park Lower Burrell, Westmoreland, Pa.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service				ADDRESS Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 3 1983	
25b. REGISTRAR'S SIGNATURE John J. Carver							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

